DOCUMENT RESUME

ED 287 850 SP 029 521

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TITLE Guidelines for School Health Services.
INSTITUTION New Jersey State Dept. of Education, Trenton. Div. of General Academic Education.
PUB DATE 86
NOTE 163p.
AVAILABLE FROM New Jersey State Department of Education, Distribution Services, 225 West State St., Trenton, NJ 08625 ($6.25).
PUB TYPE Guides - Non-Classroom Use (055)

EDRS PRICE MF01/PC07 Plus Postage.
DESCRIPTORS Elementary Secondary Education; *Health Education; Immunization Programs; Institutional Environment; Prevention; *Public Schools; *School Health Services; School Nurses; School Responsibility; *School Role; Screening Tests; *State Standards
IDENTIFIERS *New Jersey

ABSTRACT

This publication was designed to assist chief school administrators, school nurses, school physicians, staff, and other school health personnel in developing, implementing, and evaluating sound school health programs for New Jersey public school students. Section I delineates responsibility for school health services, discussing the role of district boards of education, school nurses, school physicians, school nurse supervisors, dentists, and optometrists. Section II, on pupil health appraisal and assessment, discusses health appraisals and audiometric, tuberculosis, scoliosis, vision, and blood pressure screening. Immunization monitoring, observation of pupils with communicable diseases, first aid and emergency care, and administration of medication are addressed in Section III. Health supervison of school personnel is discussed in Section IV. Supervision of the environment is the topic of Section V, in which the physical environment, eye protection, emotional climate, and the health services office are discussed. Appendices present New Jersey statutes regarding school health, alcohol, and drugs; an admininstrative code regarding school health, safety, and physical education; and a list of nursing/health professional organizations, resources, and publications. (CB)

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GUIDELINES FOR SCHOOL HEALTH SERVICES

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FOREWORD

School health services are an important component of the activities within a school. Designed to promote health and wellness of pupils, a comprehensive school health program has three interrelated, yet separate components. These are school health services, a healthful school environment, and health education.

Health services are largely the responsibility of the school nurse, but effective delivery of these services requires the cooperative efforts of the school administration, staff, and the entire school community. These services aim to help each pupil achieve and maintain optimal health. Health education helps our students to acquire decision-making skills, learn to assume responsibility for personal, family, and community health and become wise and assertive consumers. While health instruction is primarily the function of the classroom teacher in cooperation with the school nurse, health education is a function of all school personnel. It is the school's responsibility to provide a healthy school environment that is a safe physical, social and emotional setting for each child. Its maintenance rests primarily with the administration in cooperation with the school staff.

This publication is designed to assist chief school administrators, school nurses, school physicians, staff, and other school health personnel in developing sound school health programs for their pupils.

Saul Cooperman
Commissioner of Education

ACKNOWLEDGMENTS

Sincere thanks are extended to all of the dedicated professionals who cooperated and assisted in the preparation and review of this document. These individuals include: Dr. Elena Scambio, coordinating county superintendent, northern region; Dr. Virginia Brinson, coordinating county superintendent, central region; and Peter B. Contini, coordinating county superintendent, southern region, who provided valuable guidance in the area of school health services for local districts. We also wish to acknowledge with gratitude the following expert consultants who also reviewed this document: Dr. George Halpin and Dr. Mary Teter, State Department of Health; Dr. Carlo Melini, New Jersey Academy of Pediatrics; Dr. Glenn Lambert, New Jersey Medical Society; Carol O'Neill, New Jersey Society to Prevent Blindness; Hazel Kogler, R.N., President, New Jersey State School Nurses' Association; and Barbara Norton, R.N., Glassboro State College School of Nursing.

A special acknowledgment is extended to Dr. Joel Bloom, assistant commissioner, Division of General Academic Education, and Dr. Jacqueline Cusack, manager, Bureau of Student Behavior and Development, under whose direction the final draft of this document was completed. Jane De Maio, Division of General Academic Education, who assisted in the final stages of the writing, editing and review of this document is given special thanks for her cooperation and guidance. Special thanks are also expressed to Dr. Arnold Webb, former assistant commissioner, Division of Educational Programs, and Dr. Paul Winkler, former director, Regional Curriculum Services Unit - South for their support during the developmental stages of this revised edition.

Finally, special thanks are extended to the support staff of the department who typed and proofread this manual, to Florence Cucchi who edited the final copy, and to Elease Greene-Smith who reviewed all law and code citations in this document.

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PHILOSOPHY AND GOALS OF SCHOOL HEALTH SERVICES

Health may be defined as that state in which an individual functions to the best of his/her capabilities - physically, intellectually, emotionally and socially. The school has the responsibility and opportunity to influence the health of school children and therefore that of our future generations. School health services, an integral part of the school system in New Jersey, are designed to maximize an individual's health potential and provide a broad spectrum of health services for children and adults in both public and private sectors of the community.

The quantity and quality of pupil learning is in direct proportion to their health status and to their abilities to improve or adapt to any limitations. While it is recognized that all members of the school staff and other professionals contribute expertise in specialized health areas, the major responsibilities for pupil health are in the hands of the health service specialists - the school nurse and school physician.

The goals of the school health services program are to:

1. identify health problems and needs of pupils and staff;

2. assist pupils in becoming increasingly responsible for their own health;

3. promote the optimal level of health for pupils and staff;

4. promote environmental safety and health within the school and during school-related activities;

5. provide health education and health counseling for pupils, parents and staff;

6. provide direct health services in an efficient and cost-effective manner; and

7. maintain a liaison with primary health care providers.

The Guidelines for School Health Services has been revised to assist the school nurse and other staff in developing, implementing, and evaluating a school health service program. It addresses a number of areas including responsibility for school health services, pupil health appraisal and assessment, public and school personnel health supervision, health teaching and counseling, and supervision of environment. Laws and regulations from the Departments of Education and Health that pertain to school health services are included in the appendices as well as the text.

CHAPTER I

RESPONSIBILITY FOR SCHOOL HEALTH SERVICES

1. DISTRICT BOARDS OF EDUCATION AND CHIEF SCHOOL ADMINISTRATORS

Administrative policies for school health services will vary depending on the size of the district, the grade levels served and the needs of pupils in a particular community. The local district board of education is legally responsible for budgeting for the employment of health services and support personnel (N.J.S.A. 18A:40-1), and should review and approve all health policies and programs to be implemented in the district.

The chief school administrator in concert with the school is the key person in developing and implementing a comprehensive school health program which includes school health services, health education and a healthful school environment. In order to prepare pupils to function effectively and maintain a state of wellness and physical fitness, health services and health education should become priorities.

Certain health services are mandated by the New Jersey Statutes and others by the New Jersey Administrative Code. The employment of certified school nurse(s) and medical inspector(s) is mandated by N.J.S.A. 18A:40-1.

The local district is responsible for the utilization of all health professionals in order to meet the health needs of pupils. The school physician and the school nurse have specific functions and responsibilities. Depending upon the need demonstrated, school districts may choose to employ additional health professionals such as an optometrist and/or dentist (N.J.S.A. 18A:40-1).

The primary responsibility for pupil health care rests with the parents, the private physician and/or public or private health maintenance organization. The school assists parents by providing an extension of these health services.

2. THE SCHOOL PHYSICIAN

FUNCTIONS: The specific functions of the school physician and the degree of involvement might be defined best by a school-community health services committee comprised of representatives of school administrators, school health specialists, health educators, physical education teachers, classroom teachers and community members. Communities with many health resources and health professionals may use the school physician as an advisor and facilitator to channel health consumers (pupils, parents, staff) into these resources, whereas communities with fewer health resources may use the school physician to perform more functions within the school itself.

MAJOR RESPONSIBILITIES: School physicians have certain responsibilities as defined in the New Jersey Statutes and New Jersey Administrative Code.

Their greatest contribution can come through their participation in the child study team process; health education; planning and evaluation of school physical examinations; and advising the school district regarding health program policies.

EXTENT AND LIMIT OF AUTHORITY: The school physician is licensed by the Board of Medical Examiners and functions in accordance with New Jersey Statutes (N.J.S.A. 18A:40-1). The school physician is responsible to the chief school administrator of the local school district; he/she directs the duties of the school nurse and issues regulations governing professional techniques, the conduct of tests and administration of treatment (N.J.A.C. 6:29-3.1).

3. THE SCHOOL NURSE

FUNCTIONS: The school nurse is a health service specialist who assists pupils and staff in attaining and/or maintaining optimum health and promotes positive health habits and attitudes.

MAJOR RESPONSIBILITIES: The following duties are required by statute and administrative code and have traditionally been performed by school nurses under the direction of the school medical inspector.

1. Examine every child to determine if any physical defect exists (N.J.S.A. 18A:40-4).

2. Review immunization records for pre-kindergarten to grade 12 pupils (N.J.S.A. 18A:40-13, N.J.S.A. 26:1A -9.1 and N.J.S.A. 26:4-6).

3. Maintain student health records (N.J.A.C. 6:29-3.1(b)).

4. Care for sick and injured pupils and arrange for an appropriate course of action (N.J.A.C. 6:29-2.3).

5. Administer medication/treatment when necessary for pupils to attend school according to district boards of education policy (N.J.A.C. 6:29-3.2).

6. Assist with physical examinations for:

   a. Sports participants (N.J.A.C. 6:29-6.4);
   b. Working paper applicants (N.J.S.A. 34:2-21.8(3));
   c. Child Study Team referrals (N.J.A.C. 6:28-3.1).

7. Test for tuberculosis infection as required by the Department of Health and follow-up appropriately with students and employees (N.J.S.A. 18A:40-16 and N.J.A.C. 6:29-42).

8. Report to the Commissioner and/or the Department of Health the results of tuberculosis screening, scoliosis screening, and immunization status (N.J.S.A. 18A:40-19, N.J.A.C. 6:29-4.2 and N.J.S.A. 18A:40-4.3).

9. Annually conduct audiometric screening in grades preschool through four, six and eight, and nine or ten (N.J.A.C. 6:29-8.2).

10. Conduct yearly screenings for scoliosis on all pupils 10 years of age through eighteen years of age (N.J.S.A. 18A:40-4.3).

11. Participate in the identification, referral and health appraisal for handicapped pupils with the child study team (N.J.A.C. 6:28-3.2).

12. Provide special health care and related services to meet the needs of handicapped pupils. This includes catheterization where needed, arranging for special help, special feeding, etc. (P.L. 94-142, P.L. 93-112, Sec. 504).

13. Participate with other members of the staff in setting goals for the district health services program (N.J.A.C. 6:29-3.1).

14. Lecture to teachers on communicable diseases and other health problems and concerns (N.J.S.A. 18A:40-3).

15. Observe and recommend exclusion of students who show evidence of communicable disease such as, but not limited to, pediculosis, scabies, tinea capitis and conjunctivitis (N.J.S.A. 18A:40-7 and 8).

ADDITIONAL PROFESSIONAL SERVICES: The following additional services may be performed by the school nurse if established as policy by the board of education:

1. Monitoring growth and development (yearly height/weight)

2. Vision screening, referral and follow-up

3. Blood pressure screening, referral and follow-up

4. Health counseling for pupils, parents, and staff

5. Health supervision of school employees

6. Health teaching, as assigned, according to pupil load

7. Nutrition counseling

8. Strep Disease Control Program

EXTENT AND LIMIT OF AUTHORITY: A school nurse is licensed by the New Jersey Board of Nursing and is certified according to standards of the New Jersey Department of Education.

The nurse is responsible to the local chief school administrator or his/her designee. Medical consultation is provided by the school physician. Overall coordination of school health services in any given district may be delegated to a nursing supervisor/coordinator.

A board of education has the right to create the position of a nurse's aide (clerical aide/health aide) provided that the duties and job description are approved by the local district board of education and the county superintendent of schools. However, the duties performed by an aide cannot be the same or include those duties required to be performed by a school nurse. A board of education does not have the authority to replace duties of a school nurse by assigning such duties to an aide.

LEGAL BACKGROUND

a. **Definition/School Nurse** N.J.S.A. 18A:1-1 states:

> 'School nurse' shall mean and include any school nurse, school nurse supervisor, head school nurse, chief school nurse, school nurse coordinator or any other nurse performing school nursing services in the public school;...

b. **Definition/Teaching Staff Member** N.J.S.A. 18A:1-1 states:

> 'Teaching staff' member means a member of the professional staff of any district or regional board of education, or any board of education of county vocational school, holding office, position or employment of such character that the qualifications, for such office, position or employment, require him to hold a valid and effective standard, provisional or emergency certificate, appropriate to his office, position or employment, issued by the State Board of Examiners and includes a school nurse.

c. **Payment of School Nurse According to Teachers Salary Guide** N.J.S.A. 18A:29-4.2 states:

> Any teaching staff member employed as a school nurse and holding a standard school nurse certificate shall be paid according to the provisions of the teachers' salary guide in effect in that school district including the full use of the same experience steps and training levels that apply to teachers.

d. **School Nurse Certification** N.J.A.C. 6:11-12.9 states:

> "Authorization. This certificate authorizes services as a school nurse in elementary, secondary and vocational schools, and teaching areas related to health."

The following requirements are effective for new applicants after July 1, 1975:

- Current license as a registered professional nurse in New Jersey;
- A Bachelor's degree based upon a four-year curriculum in an accredited college;
- Successful completion of an approved college curriculum (by the New Jersey State Department of Education) or approved program of college studies; and
- Student teaching

e. **Employment Mandate** N.J.S.A. 18A:40-1 mandates the employment of school nurses. It states:

> "...any board, not furnishing nursing services under a contract pursuant to section 18A:40-3.1 shall employ one or more school nurses,..."

f. **Employment Prohibition** N.J.S.A. 18A:27-2 prohibits the employment of any teaching staff member without an appropriate certificate. It states:

"Any contract or engagement of any teaching staff member, shall cease whenever the employing board of education shall ascertain by written notice received from the county or city superintendent of schools, or in any other manner, that such person is not, or has ceased to be, the holder of an appropriate certificate required by this title for such employment, not withstanding that the term of such employment shall not then have expired."

7. **Aides' Employment** N.J.A.C. 6:11-4.5 grants the board of education authority to employ aides and requires it to develop job descriptions and standards for appointment prior to employment of such aides. It further requires that such job descriptions be adopted by the board prior to its submission to the county superintendent of schools for approval.

SCHOOL NURSING AND SOCIETAL CHANGES: In New Jersey, school nursing is and always has been a challenge. Nurses were originally employed in the schools for two specific purposes: 1) to control communicable diseases, and 2) to reduce absenteeism. Today the school nurse continues to address the ever-present problems of contagious diseases, malnutrition, vision impairments and learning problems which affect student academic performance. However, the school nurse's role has broadened to include the new and emerging health issues prevalent in our school population today such as: behavioral disturbances, learning disabilities, substance abuse, sexually transmitted diseases, child abuse, stress and suicide.

The school nurse's role today is also that of an advocate for students. With changes in the family structure and composition, in the health care system, in student health needs and in cultural lifestyles and attitudes,

students need someone with whom they can share concerns. Generally, the school nurse is one person in the school system who is a constant in the students' school experience at various levels. The elementary nurse remains at the elementary level and provides health services and supervision from preschool or kindergarten through sixth or eighth grade, depending upon the organization of the school. A nurse in the middle or secondary school usually serves these pupils for three or four years. On whatever level, the school nurse can be an anchor amid a sea of changes.

Today, more than ever before, school nurses need to keep abreast of current nursing and educational trends through professional organizations, in-service and continuing education programs, and professional readings.

SCHOOL NURSE AND SPECIAL EDUCATION: Since 1954, with the enactment of the Beadleston Act, New Jersey has been a leader in the nation in providing public school education for handicapped children. As a result of state legislation (N.J.S.A. 18A:7A, and N.J.A.C. 6:8-1.1) and federal legislation (P.L. 94:142), the right of all handicapped students to an appropriate education either in public schools or schools established for students with special needs is guaranteed and with this the role of the school nurse has indeed expanded.

Emphasis on the preschool handicapped child through P.L. 94-142 presents another challenge for the school nurse. A review of early childhood growth and development and the various screening procedures used with young children may be indicated.

Early identification of handicapped pupils and participation in the evaluation, classification and development of individualized educational programs place increasing demands on school nurses. Educational needs and goals of local districts should lead to an evaluation of the staffing patterns for health services to determine an appropriate ratio of school nurses to pupils in the local school district.

Since the number of children with varying types and degrees of handicaps attending public school has greatly increased, specific support services are necessary for these children to derive optimal benefits from their educational experience. The school nurse is prepared to assess and interpret the particular physical needs of each child. The parameters of school nursing have expanded to include many additional services needed by handicapped pupils in the school.

Each pupil's learning is affected by his/her health status and ability to adapt to limitations. While all members of the school staff have general responsibilities for pupil health, the health services specialists - school nurse and school physician - have the major responsibility. School nurses strive to encourage good health for all pupils so they may have an equal opportunity to benefit from a quality education. School health services, an integral part of the school program in New Jersey, are designed to foster good health and provide a broader spectrum of health services for children and adults in both public and private sectors of the community.

4. THE SCHOOL NURSE SUPERVISOR

FUNCTIONS: The school nurse supervisor, certified in both school nursing and administration and/or supervision, uses supervisory and administrative skills to coordinate the total school health services program and may bear responsibility for budgetary decisions regarding staffing, equipment and supplies.

MAJOR RESPONSIBILITIES: The major responsibilities of the school nurse supervisor are to:

1. Assist in the interviewing and selection of nursing and medical staff.

2. Plan orientation for new school nurses/physicians.

3. Identify with staff in-service needs, and plan or delegate responsibility for structuring appropriate in-service programs to meet these needs.

4. Assign and schedule nursing staff and physicians in collaboration with the chief school physician or medical director.

5. Confer with and advise nursing staff on specific health problems.

6. Evaluate nursing staff according to criteria and standards developed jointly by supervision and staff and approved by the local board of education.

7. Schedule screening programs and other health service activities.

8. Analyze the health services provided, seeking innovative ways to reduce the number of health problems evidenced by pupils/staff.

9. Plan for continuing professional development of staff.

10. Coordinate all data collection for surveys by the Departments of Education and Health.

11. Serve as a liaison between school health specialists, school administrators, chief school physician/medical director and public health and welfare agencies.

EXTENT AND LIMIT OF AUTHORITY: The school nurse supervisor functions under an administrator according to local district policies and consults with the chief school physician/medical inspector regarding staff assignments and all medical/health policies, procedures and programs.

Because good supervision is essential for quality health services, any district employing more than one nurse may wish to consider designating one nurse to coordinate all school health service activities. The nursing staff

should be given direction and kept abreast of changes in policies, programs and procedures. It is advantageous for districts with ten (10) or more nurses to employ one as nursing supervisor; this, however, is not mandated.

5. THE DENTIST

While the New Jersey statutes neither require the employment of a dentist nor implementation of a dental examination program, there is a need for such a program in some areas of the state. The extent of the dental services provided should be determined jointly by the school and community, based on the identified dental needs of pupils and lack of public and/or private services available.

FUNCTION: The dentist, licensed in New Jersey, is employed by a school district to: 1) direct the professional activities of the dental assistant or nurse assigned to the dental services; 2) to examine pupils; 3) to treat with parental consent; and 4) to record results of examinations, treatment rendered and recommendations for dental care.

EXTENT AND LIMIT OF AUTHORITY: The dentist functions in the school under the direction of the local chief school administrator with medical consultation of the school physician, and is responsible to provide quality care and treatment when so contracted. All dental health records are the property of the local school district board of education.

DENTAL HEALTH SERVICES: The type of dental health services provided by the local school district is determined by the district (N.J.A.C. 6:29-4.1). A minimal dental health program would include:

- Dental health education with specific concepts presented at appropriate age levels from kindergarten through 12th grade;

- Examination of teeth at the time of the physical examination.

A more productive and effective program would make provision for the dental examination to be performed by a dentist (public or private) or a dental hygienist.

Methods to motivate parents/guardians and pupils to seek professional dental care are of prime importance. The effectiveness of a good dental health program can best be measured by a reduction in the number of pupils with dental caries and the number with dental problems who receive treatment. Reparative dentistry should be limited to pupils for whom a financial need has been determined and a consent has been signed by the parent/guardian.

6. THE OPTOMETRIST

FUNCTIONS: Some local districts employ a licensed optometrist as a vision examiner to supplement the vision screening performed by the school nurse.

The school optometrist should have experience in working with school-age pupils. The role can be expanded through participation in appropriate aspects of health education curriculum development and instruction.

EXTENT AND LIMIT OF AUTHORITY: The optometrist functions in the school under the direction of the chief school administrator with medical

consultation of the school physician, and is responsible to provide quality service according to the terms of a contract. All vision examination records are the property of the local district board of education.

Chapter II

PUPIL HEALTH APPRAISAL/ASSESSMENT

New Jersey statutes mandate that "the medical inspector or the nurse, under the direction of the medical inspector, shall examine every pupil to determine if any physical defects exist," or in lieu thereof, the medical inspector may accept the report of such an examination by a physician licensed to practice medicine and surgery within the state (N.J.S.A. 18A:40-4).

1. HEALTH APPRAISALS

A comprehensive health appraisal includes a complete health history and a thorough physical examination of a pupil performed by a school physician or a private physician. The health history includes social, emotional, and developmental factors as well as other health information. The complete physical examination incorporates a review and examination of all body systems.

Since the primary responsibility for the health of the child rests with the parent/guardian and a primary care provider, a comprehensive health examination completed prior to entering school should be the foundation for the school health appraisal. If this cannot be done, the school should assume the responsibility for the initial health assessment utilizing the school physician with the assistance of the school nurse.

In addition to the pre-entry health appraisal, the pupil should be scheduled for examination in about the fourth or fifth grade, seventh or eighth grade, and the tenth or eleventh grade or age equivalents. However, the grade level for routine physical examinations is the decision of local districts, and the state does not mandate specific grades to be examined. A parent may request in writing an exemption from the thorough physical examination by the school physician because of religious beliefs. Such a statement must be signed by the parent/guardian (N.J.S.A. 18A:40-4).

As part of the health appraisal, growth and development assessment should be regularly conducted by one of the health specialists during childhood and adolescence unless suspected or existing conditions warrant greater frequency. The use of percentile growth charts can enable the specialist to graph a child's growth and development. The significance of the changing growth and developmental patterns observed in the assessment should be discussed with the individual and/or parent/guardian in order to promote his/her awareness and responsibility (commensurate with development) for achieving and/or maintaining optimal growth and development.

New Jersey statutes and administrative code require other health appraisals. The following five areas are discussed briefly below: a) health appraisal for the child study team; b) examination to determine fitness to participate in physical education; c) examination for scoliosis; d) evaluation for sports participation; and e) examination for working papers.

A sample of Form A-45 which many schools use for recording the child's health history is included at the end of this section for your information and convenience.

a. **Health Appraisal for the Child Study Team** The New Jersey Administrative Code requires a comprehensive health appraisal on every child referred to the child study team for evaluation. Please refer to special education rules and regulations (N.J.A.C. 6:28). Based on N.J.A.C. 6:28-3.4(e), a comprehensive evaluation for handicapped pupils ages three to 21 shall be performed by a physician employed by the district board of education in accordance and consist of the following:

- The comprehensive health appraisal shall include, but not be limited to, an assessment of prenatal, perinatal, postnatal factors, developmental and early childhood illnesses and injuries and a review of health screenings.

- The school physician shall examine the pupil, including all body systems, and write a summary indicating the effect of any current health problem or medical treatment on the pupil's learning.

- If the parent(s) of the pupil chooses to employ a private physician, a report of this comprehensive health appraisal shall be completed on a form developed by the school physician.

- The school nurse shall review and summarize all other available health information regarding the pupil and transmit it to the child study team.

b. **Examination to Determine Fitness to Participate in Physical Education** Although a parent may request an exemption from the thorough physical examination by the school physician because of religious beliefs, a pupil may still be examined to the "extent necessary to determine whether he/she is ill or infected with a communicable disease or to determine his/her fitness to participate in any health, safety or physical education course required by law" (N.J.S.A. 18A:40-4).

c. **Examination for Scoliosis** An examination for scoliosis is required for all pupils over 10 years of age. However, a pupil may be excused from scoliosis examination upon the written request of the parent/guardian (N.J.S.A. 18A:40-4.3). A fuller section on scoliosis is included later in this publication.

d. **Participation in Sports Programs** Good physical condition and freedom from injury and full recovery from illness shall be prerequisite to participation in athletics, whether in practice or in competition. This would necessitate a complete medical examination which must be completed no more than 60 days prior to the first practice session (N.J.A.C. 6:29-6.4). Only one medical examination per school year is mandated for participation in one or more sports.

e. **Examination for Working Papers** Pupils seeking employment as minors must be examined by the school physician or another physician licensed to practice medicine and surgery in New Jersey. The statement must be signed by the school medical examiner indicating the pupil is physically fit for the type of employment sought (N.J.S.A. 34:2-21.8).

NJDEC05000285

HEALTH HISTORY AND APPRAISAL

Name of Child (Last, First, M.I.)	Birth Date (Mo/Day/Yr)	Sex ☐ Male ☐ Female

PARENT	Name	Phone No.
	Address	

VACCINE TYPE	DISEASE Mo/Yr	PRIMARY SERIES 1st Dose Mo/Day/Yr	PRIMARY SERIES 2nd Dose Mo/Day/Yr	PRIMARY SERIES 3rd Dose Mo/Day/Yr	BOOSTERS Mo/Day/Yr	BOOSTERS Mo/Day/Yr	BOOSTERS Mo/Day/Yr
Diphteria & Tetanus (DPT and/or Td)							
Polio—indicate Oral or Salk in corner box. Oral—if monovalent indicate type 1, 2, 3 in corner box, Salk—acceptable if given after 12/31/67							
Measles							
Rubella							
Mumps							

Contra-Indications (Kind)

Reactions to Immune. (Type)

DISEASE HISTORY	TYPE		YEAR		YEAR	OPERATIONS OR INJURIES	YEAR
ALLERGIES		ASTHMA		OTITIS MEDIA			
CONGEN. DEFECTS		CHICKEN POX		RHEUMATIC FEVER			
DRUG SENSITIVITIES		CONVULSIVE DIS.		STREP INFECTIONS			
HEPATITIS		DIABETES		MONONUCLEOSIS			
NEUROMUSC. DIS.		HEART DISEASE		OTHER			

HEALTH SCREENING Code: N = Normal; R = Referred; T = Under Treatment; C = See Comments

Grade/Age															
Date															
Height															
Weight															
Blood Pressure															
VISION	With glasses	R													
		L													
		BOTH													
	Without glasses	R													
		L													
		BOTH													
	Muscle Balance														

Color Perception — Date — Results

HEARING	Date														
	Sweep Check	P													
		L													
	Complete Pure Tone	R													
		L													
SCOLIOSIS SCREENING (Beginning at Age 10)															

TB Screening: Date _____ Results: Neg. _____ Vesiculation _____ Induration (mm) _____

Follow-up: X-ray (date) _____ Results _____

Rx: INH (date started) _____ (date completed) _____

STATE OF NEW JERSEY—DEPARTMENT OF EDUCATION/DEPARTMENT OF HEALTH

(A-45)

Name _____

PHYSICAL EXAMINATION

Grade/Age														
Date														
Ears (otoscopic)														
Eyes														
Lymph Glands														
Thyroid														
Nose														
Throat														
Teeth-Mouth														
Heart														
Lungs														
Abdomen														
Hernia														
Genito-Urinary														
Ortho-pedic — Structural														
Ortho-pedic — Posture														
Ortho-pedic — Feet														
Skin (Non Comm.)														
Nutrition														
Nervous System														
Speech														
Other														
General Appearance														
SIGNATURE OF PHYSICIAN														

DATE	RECORD: Findings and Recommendations of Physicians; Modification of School Program; Referrals and Follow-up; Conference with Parents, Teachers; Counseling with Student.	SIGNATURE

2. AUDIOMETRIC SCREENING

DEFINITION AND RATIONALE: Hearing loss has often been called a hidden handicap and needs to be identified early to insure that the development of a pupil's language and oral communication will not be affected. Impaired hearing ability interferes with normal emotional/social interactions and the educational process itself.

A comprehensive hearing conservation program includes: 1) planning and observation, 2) screening, 3) referral and 4) follow-up. Environmental and safety factors should always be stressed. The following brief definitions of terms are excerpted from the administrative code (N.J.A.C. 6:29-8.1).

> "Audiometric screening" is a procedure used to determine a pupil's response to an auditory signal at a given frequency and decibel level.
>
> "Health care personnel" refers to a certified school nurse or an employee of the district board of education who is trained in audiometric screening and working under the immediate direction of the medical inspector, including but not limited to speech correctionists and audiologists.
>
> "Pupils at risk for hearing impairment" are those pupils with communication disorders, pupils with cleft palate, pupils with allergies, pupils with frequent upper respiratory or middle ear infections, pupils taking ototoxic medication, and/or pupils who are exposed to sudden or continuous loud noises.
>
> A "screening room" is any environment in which an adult with normal hearing can hear a 20dB HL signal at the frequencies of 500Hz, 1000Hz, 2000Hz, 3000Hz and 4000Hz.

IMPLEMENTATION: Districts should consider the following in planning and implementing procedures for their audiometric screening programs:

- Teacher observations of student inattention, behavioral problems, speech and language problems, requests for repetition of verbal directions and/or turning their heads to hear should be considered significant by the nurse.

- Pupils should be prepared and informed of the purpose of the hearing screening, the procedure to be followed and the importance of correcting any hearing losses or deficiencies. The nurse should incorporate age-appropriate health education concepts about the ears and stress how to prevent ear injuries and hearing losses. Also, a demonstration of the hearing screening procedure is important for very young children.

- In accordance with N.J.A.C. 6:29-8.1 and 8.2, pupils who should be screened are those who are:

  a. Enrolled in pre-school programs

  b. Enrolled in grades kindergarten through 4

  c. Enrolled in grades 6, 8, and 9 or 10

  d. Entering the district with no recent record of hearing screening

  e. At risk for hearing impairment

  f. Referred to child study team for evaluation

  g. Referred for screening by a teacher, a parent or at pupil's own request

- The medical inspector, certified school nurse, or other health care personnel shall conduct the hearing screening. All screening shall be conducted in cooperation with the school nurse. (N.J.A.C. 6:29-8.2)

- Each pupil shall be individually screened with an audiometer which is calibrated annually in accordance with ANSI S3.6-1969 "American National Standards Specification for Audiometers," at 20 dB HL in a screening room at the following frequencies: 500 Hz, 1000 Hz, 2000 Hz, 3000 Hz, and 4000 Hz (N.J.A.C. 6:29-8.2).

- A pupil who fails to respond to any one frequency in either ear shall be screened again in four to six weeks (N.J.A.C. 6:29-8.2).

- If a pupil fails to respond to the same frequency or frequencies in the same ear on the second valid screening, that pupil shall be considered to have failed the screening and should be referred for further evaluation (N.J.A.C. 6:29-8.2).

- A pupil who fails to respond at a different frequency or different frequencies on the second screening shall be screened a third time within two weeks (N.J.A.C. 6:29-8.2).

- A pupil who fails to respond at any one frequency on the third screening shall be considered to have failed the screening and should be referred for further evaluation (N.J.A.C. 6:29-8.2).

- The parent or guardian of pupils failing auditory screening shall be notified in writing by the school nurse of the necessity for additional evaluation by a physician or family health care provider (N.J.A.C. 6:29-8.2).

3. TUBERCULOSIS SCREENING

DEFINITION AND RATIONALE: The objectives of a tuberculosis screening program in the schools are to: 1) identify significant tuberculin reactors; 2) make appropriate referrals; and 3) insure follow-through. The mandatory requirements for tuberculosis screening in the schools are found in New Jersey regulations code N.J.A.C. 6:29-4.2, and are based upon state law N.J.S.A. 18A:16-2 and N.J.S.A. 18A:40-16.

IMPLEMENTATION: The Board of Education must often assume full responsibility for the program in public schools, while the local or county health department should take the initiative for non-public schools. All pupils in all grade levels transferring into New Jersey schools from out of state or out of country without a valid record of a Mantoux tuberculin test must be tested. New Jersey regulations, as quoted below, specifically require the exclusive use of the Mantoux intradermal test with 5TU of stabilized PPD Tuberculin.

All testing should be completed and the final reports, whether testing was completed or not, should be submitted to the New Jersey State Department of Health by December 31 of each year. Specific questions concerning the rules or use of the reports, may be referred to the Department of Education, Division of General Academic Education, (609)984-1890 or the Department of Health, (609) 292-7100.

When possible, planning for this program should take place in a defined region or on a county-wide basis. The school nurse and/or school physician

should take the initiative in organizing a coordinating committee to help in planning a school district tuberculin testing program. Representatives on the coordinating committee should include the school administrator, the school physician, school nurse, a board member, a member of the local or county health department and a PTA representative. This coordinating committee should determine: 1) financing and budgeting, 2) personnel needed for testing, follow-up, record keeping and analysis, 3) a time schedule, 4) a public relations program to interpret objectives and results, 5) educational aspects of the program, 6) recruitment of volunteers, and if necessary, 7) the appointment of subcommittees to help implement the project.

RESPONSIBILITIES OF THE SCHOOL PHYSICIAN: The school physician should maintain a liaison with the appropriate TB control agency and medical facility. He or she will administer the Mantoux tuberculin test, or provide written authorization for the school nurse to administer and read the test. The school physician will refer those with significant reactions to the family physician or an appropriate clinic for diagnosis, preventive therapy and follow-up. He/she will review the documented results of all previous tuberculin testing, review recommendations of family physicians and clinics to which pupils have been referred, and maintain a continuing interest in pupils and employees who have been placed on preventive isoniazid (INH) therapy.

RESPONSIBILITIES OF THE SCHOOL NURSE: The school nurse is responsible for the orientation and the inservice education and guidance of school personnel regarding the policies and objectives of the tuberculin testing program, while also emphasizing the importance of INH preventive therapy. He/she

plans with the appropriate medical and administrative personnel within the school for the administration and reading of the test and the necessary follow-up, including INH chemoprophylaxis when prescribed. The school nurse also develops a record system for recording the tuberculin test results, the date INH was prescribed and the date completed.

With the written authorization of the school physician, the nurse can perform the Mantoux tuberculin test, and read and record the test results. The school nurse may administer the intradermal tuberculin test as specified in an official statement approved by the State Board of Medical Examiners and the New Jersey Board of Nursing. (See N.J.A.C. 13:37-6.1; a copy is included at the end of this section.)

THE ADMINISTRATION OF TUBERCULIN TESTS: Use of the intradermal Mantoux test with 5 TU of stabilized PPD tuberculin is mandatory and is nationally recognized as the only definitive tuberculin test. The regulations governing the administration of the Mantoux test are quoted below from N.J.A.C. 6:29-4.2 - Testing for Tuberculosis Infection.

1. The Mantoux intradermal tuberculin test using five T.U. (Tuberculin Units) of PPD tuberculin shall be the only skin test used to detect evidence of tuberculosis infection in pupils and employees.

2. The only pupils who shall be tested are those in grades and schools identified and/or under circumstances specified by the State Department of Health based upon the high incidence of tuberculosis or reactor rates in the communities or population groups concerned.

3. In every school district a Mantoux intradermal tuberculin test shall be given to all employees (full-time and part-time), all student teachers, and other persons who have contact with pupils. If the Mantoux intradermal tuberculin test shows less than 10mm of induration, the above persons shall be retested with a Mantoux intradermal tuberculin test every three years.

4. Any pupil or employee shall be exempt from these requirements upon presentation of documentation of a prior significant reaction evidenced by vesiculation following the administration of a multiple puncture tuberculin test or a significant reaction (that is, 10mm or more of induration) following a Mantoux intradermal tuberculin test with five tuberculin units of stabilized PPD tuberculin. Any other exemption from these requirements shall be because of medical contraindications subject to review by the medical inspector.

5. All tuberculin reactors as defined in 4 above shall be referred to the family physician and appropriate official health agency for necessary follow-up. The following shall constitute standards for referral:

   i. If there is documentation showing that vesiculation resulted from a previous multiple puncture test, the individual shall be recorded as a positive tuberculin reactor, and no further tuberculin testing is required.

   ii. If the reaction to the Mantoux intradermal tuberculin test is doubtful (five to nine mm of induration), it shall be repeated at a different site on a forearm. If the result of the second Mantoux intradermal tuberculin test is also five to nine mm of induration, the individual shall be recorded as tuberculin negative. If the result of the Mantoux test shows 10 or more mm of induration, the individual shall be recorded as a tuberculin reactor, and no further tuberculin testing is required.

6. A chest X-ray shall be administered to all pupils, employees and other personnel who have a significant reaction to a Mantoux intradermal tuberculin test as defined in 4 above.

7. All pupils, employees and other personnel required to have a chest X-ray shall be referred to their family physician or other medical facility for the necessary medical evaluation, including a chest X-ray. If the physician's report is not received by the school physician within four weeks, or if the school physician is unwilling to accept the findings, the pupil, employee or other persons who have contact with pupils shall have a chest X-ray examination in the manner prescribed by the district board of education.

8. If the chest X-ray of a tuberculin reactor is negative for evidence of tuberculosis, chemoprophylaxis or preventive therapy, with one year of isoniazid (INH) is strongly recommended.

9. A tuberculin reactor who is certified in writing by a licensed physician to have completed one year of preventive treatment (chemoprophylaxis) with isoniazid (INH) shall not be required to undergo any further testing for tuberculosis.

10. Employees and pupils who have a significant reaction to the Mantoux intradermal tuberculin test and an initial chest X-ray that was negative, or who present a medical certificate showing a significant tuberculin reaction and a subsequent negative chest X-ray, shall require no further testing for tuberculosis infection.

11. The reporting of the testing for evidence of tuberculosis infection by each district board of education shall be as follows:

    i. The name and address, grade (of pupils), age and school of all newly discovered tuberculin reactors, chest X-ray results and prescription of preventive therapy are to be reported immediately upon discovery to the New Jersey State Department of Health, and to the local health department or local tuberculosis control center, on a special form provided for this purpose so that the appropriate tuberculosis control measures can be instituted;

    ii. At the end of the annual tuberculosis testing program for staff and in grades and schools as specified by the New Jersey State Department of Health, the following information shall be reported to the New Jersey State Department of Health, and the local health department or tuberculosis control center, with one copy to be retained by the district board of education:

        (1) The number of Mantoux tuberculin tests performed by grade and school, on pupils, employees and other persons who have contact with pupils

        (2) X-ray findings

        (3) Number of pupils and employees for whom isoniazid prophylaxis was prescribed

        (4) The name, address, date of birth, school and grade of each case of tuberculosis found as a result of the Mantoux intradermal tuberculin testing program

PROCEDURES FOR MANTOUX TESTING:

Site of test The left forearm should be used, so that uniformity will be insured. If the left forearm is unsatisfactory, the right may be used, but the record should so indicate.

Cleansing Before administering the test, the surface of the upper third of the mid-forearm should be cleansed with a mixture of equal parts of acetone and 70% alcohol. The skin must be clean and dry before testing.

Syringes Disposable sterile tuberculin syringes with needles should be purchased as units. The needle should be 3/8 inches long, platinum (26 gauge) or steel (27 gauge).

Preparation Grasp the underpart of the forearm with one hand and exert pressure downward to tighten the skin. Hold syringe horizontal to arm, and insert the tip of the needle with bevel up, between the layers of the skin on the volar surface of the forearm.

Injection As superficially as possible, inject 0.1 ml of the solution. A pale elevation of the skin, 6 to 10 mm in diameter and resembling a mosquito bite or blister will be produced when the fluid is properly injected intradermally. If the wheal is smaller than 6mm, the injection should be repeated at another site at least two inches below the original site.

Disposal Dispose of the syringe and needle immediately, in a way which will insure that they cannot be used again. See section which follows for the legal requirements.

Reading Read the reaction 48 to 72 hours after administration. Reading should be done in a good light with the forearm slightly flexed. The reaction is classified on the basis of induration, which may be determined

by gently stroking with a finger. The size of the reaction must be measured and the transverse diameter recorded in millimeters of induration. Induration is defined as hardness, which should be palpated to determine its extent. It must not be confused with swelling or redness.

The diameter of the induration (area of hardness) should be measured transversely to the long axis of the forearm and recorded in millimeters. Erythema or redness, and edema or swelling without induration are without significance, and should not be measured. If a reaction of 5 to 9 mm occurs, the test must be repeated, on the right forearm, in accordance with N.J.A.C. 6:29-4.2(5)ii, under the Testing for Tuberculosis Infection regulations cited earlier. Induration of 0 to 9 mm is not considered significant. Those with induration of 10 mm or more are counted as reactors on Form TB-57.

Destruction of Used Syringes and Needles: The Centers for Disease Control (CDC), Joint Commission on Accreditation of Hospitals (JCAH) and the Environmental Protection Agency (EPA) currently recommend that contaminated needles should not be clipped, broken, bent, recapped or otherwise manipulated by hand since the use of some needle-cutting device has resulted in aerosolization or splattering of blood. Additionally, the reusable cutters must be emptied and cleaned and if a cutter is not readily available, intact needles may be discarded in non-impervious containers. All of these situations increase the risk of exposure to blood. Contact your local health department for the most current recommendations in regard to the proper disposal of needles and syringes.

NOTIFICATION TO PARENTS: It is recommended that a letter be sent to parents notifying them of the testing procedures. (See sample Parent Notification of Tuberculin Testing Program letter at the end of this section.) Such a letter or notice may include the following:

1. Grade or grades in which the Mantoux tuberculin test will be given
2. Method of reporting findings to parents and family physicians
3. Request for notification if student:
   - was vaccinated with BCG
   - was a previous reactor to a tuberculin test
   - received measles or other immunizations within the preceding six weeks
4. Request for a physician's certificate showing result of any recent tuberculin test
5. Information about the Mantoux test (safe, simple and no more painful than a pinprick)

SCHOOL HEALTH RECORDS AND REPORTS OF TUBERCULIN REACTION TO PARENTS: The test results expressed in millimeters of induration (as well as the medical recommendation for preventive treatment with INH) should be recorded on the student's school health record. In all cases of significant tuberculin reactions, the parent should be notified as soon as possible. (See sample Parent Notification of a Significant Tuberculin Reaction letter at the end of this section.) The parent should also be advised that the family physician has been notified. The parent should be urged to take the child promptly to the family physician or an appropriate health facility for a thorough medical examination, including a large chest X-ray (not 70mm), and therapy as needed. Also, the parent should be advised to have all family members tuberculin tested and evaluated as necessary.

REFERRAL AND REPORT TO FAMILY PHYSICIAN: Pupils, employees or other personnel with significant tuberculin reactions must be referred to their family physicians or to an appropriate health facility for follow-up, including an X-ray. X-raying of classes by mobile X-ray units is not recommended. New Jersey State Department of Education rules state that four weeks should be allowed for the family physician to report his/her findings to the school health service. (See sample Physician Notification of a Significant Tuberculin Reaction letter at the end of this section.) If no report is received after two weeks, the private physician or clinic should be contacted. If no report is received by the end of four weeks, or if the school physician does not agree with the family physician's findings, the pupil, employee or any other personnel in contact with pupils shall receive a chest X-ray examination in the manner prescribed by the school district, as required by the rules of the State Department of Education (N.J.A.C. 6:29-4.2).

OTHER REQUIRED REPORTS: Each school district is required to submit the reports cited below. Copies of these form reports are provided at the end of this section. They may be obtained from the New Jersey State Department of Health, CN 360, Trenton, New Jersey 08625, (609) 292-7100.

1. **TB-42 Report of Significant Tuberculin Reactions** - This report lists the name, address, birthdate, sex, and grade or employee status of all persons with significant tuberculin reactions. It does not list pupils tested in other school districts. Copies of the completed form are distributed within one week after completion

of the program to State Department of Health. Copies go to the local public health authority or tuberculosis control unit and one copy is retained by the school health officer.

2. **TB-57 Annual Report of Tuberculin Testing** - In January the aggregate data from the fall tuberculin testing is sent on this report form to the State Department of Health, County Office of Education, New Jersey State Department of Education, and to the local health department or tuberculosis control agency. One copy is retained by the local school district.

PREVENTIVE THERAPY FOR TUBERCULOSIS INFECTION: An individual infected with M. tuberculosis faces the continuing possibility of developing active disease in his/her lifetime. This risk can be greatly decreased and the development of disease prevented through the daily use of isoniazid (INH) for one year. Chemoprophylaxis apparently acts by diminishing the bacterial population in "healed" or invisibile lesions in the person taking the drug. It treats the infection and prevents clinical disease from developing.

Isoniazid (INH) is the most effective preventive agent currently available. Well-documented studies have proven that when given to persons with significant tuberculin reactions, INH markedly reduces the incidence of clinical tuberculosis disease developing in later life. Dosage should be individualized, and children should be referred to private physicians or appropriate clinics.

The recommended dosage is 10 mg. per kilogram of body weight or 4.5 mg. per pound not to exceed 300 mg. daily, for one year. The medication should be administered in a single daily dose, as a larger dose or longer period of time will not provide greater protection.

Children tolerate INH very well and do not require the concomitant administration of pyridoxine (vitamin B-6). If the child's nutritional status is poor, the use of multiple vitamins may be indicated.

Based on extensive use of millions of people worldwide, Isoniazid has been demonstrated to be a relatively nontoxic drug. All recipients of preventive therapy should be monitored monthly for signs and symptoms of hepatic dysfunction. If side effects occur, the individual should be advised to discontinue taking INH immediately and to report promptly to the school nurse, clinic, or private physician for evaluation.

Abnormal changes in liver functions can occur in individuals receiving INH preventive therapy, but progressive liver disease rarely occurs in INH recipients younger than 35 years of age. And while the chance of developing INH-associated liver disease exists only during the year of preventive therapy, the risk of developing tuberculosis disease is present for life.

PERSONS FOR WHOM PREVENTIVE THERAPY IS RECOMMENDED: The use of Isoniazid with appropriate safeguards must be based upon weighing the benefits of preventive therapy against the risk of hepatic injury. Anyone with a significant tuberculin reaction is at some risk of developing tuberculosis disease at some point during his/her lifetime, and can therefore benefit

from preventive treatment with INH. The protection against developing tuberculosis disease lasts for many years, and may last for life. And since the risk of tuberculosis increases during adolescence and early adult life and decreases during later years, the benefit of INH preventive therapy for tuberculin reactors under age 35 clearly out weighs the risk of hepatitis.

Persons who have previously had a complete course (one year) of preventive therapy with INH should not be retested. See N.J.A.C. 6:29-4.2(9). Persons aged 35 or over who have a significant tuberculin reaction and have normal chest X-rays should be considered for preventive therapy on an individual basis. Medical consultation is available to physicians from the Communicable Disease Control Services, State Department of Health, CN 360, Trenton, New Jersey 08625, phone: (609)292-7100.

NURSING GUIDELINES FOR PREVENTIVE THERAPY: Prevention of tuberculosis through the use of isoniazid prophylaxis is the main objective of the school tuberculin testing program. Nursing responsibilities in this area include the following:

1. Record the results of the tuberculin test, chest X-ray and medical order for preventive therapy, including the medication, dosage and by whom prescribed. Chart this information on the pupil's individual school health record.

2. Report the results of the follow-up examinations of tuberculin reactors, and the recommendations for preventive therapy on Form TB-42.

3. Coordinate the services regarding reactors with the public health or community nursing agency to insure that explanations and interpretations of medical findings and recommendations made to the patient and family agree.

4. Understand and explain current concepts of preventive therapy when medically ordered.

5. Talk periodically with the child about the medication, i.e., when and how he takes it, when he obtained his last supply. Maintain continuing interest in the child's welfare, but avoid handling him as a special case. Monthly checking is essential.

6. Observe the child for any unusual reaction and immediately report it to the clinic or community nurse responsible for follow-up, as well as to the school physician.

7. Be prepared to explain the purpose and need for continuing INH preventive therapy as prescribed. Note: This is mainly the responsibility of the public health or community nursing agency responsible for follow-up, but the school nurse, too, must have complete knowledge in order to reinforce the necessary teaching for a successful prevention program.

ADDITIONAL CONSIDERATIONS: A BCG Vaccination does not result in permanent or complete immunity, as immunity diminishes after several years. A child who has received BCG should be given the Mantoux tuberculin test using 5 TU

of PPD. If the child has a significant reaction to the Mantoux test (10 mm or more of induration), he or she must have a medical examination including a chest X-ray.

TUBERCULIN SENSITIVITY: Although tuberculin skin sensitivity tends to persist once acquired, it may wane with advanced age; decrease or disappear if INH preventive treatment is given in the earliest stage of infection; decrease or disappear temporarily during severe illness, after measles, or other live virus immunizations, during high fever, in sarcoidosis, during overwhelming miliary or pulmonary tuberculosis, and during the administration of corticosteroid hormones.

Tuberculin testing may be done before immunization with viral vaccines against measles, rubella (German measles) or mumps, or 8 to 12 weeks after such immunizations.

NONPUBLIC SCHOOLS: The rules of the New Jersey State Department of Education apply to public schools only. Students in all other schools, however, should be provided the same benefits as public school students through the local or county health department.

Sample Letter

PARENT NOTIFICATION OF TUBERCULIN TESTING PROGRAM

Date _____

Dear Parent or Guardian:

Your school will shortly conduct a Tuberculin Testing Program, as required by the rules of the State Department of Education, and New Jersey law.

This simple test will show whether your child has been exposed to the germs which cause tuberculosis.

If your child has a significant tuberculin reaction, a chest X-ray will be necessary to see if there is any evidence of lung disease.

If the chest X-ray is normal, the doctor will usually recommend that the child take a single dose of isoniazid (INH) for one year. This simple measure is the best available means for preventing the development of tuberculosis disease now, and in the later years of your child's life.

If you have information or records about a previous tuberculin test reaction, chest X-ray, BCG vaccination; or if your child has been immunized against measles, mumps, polio, or rubella (German measles), in the past two or three months, please notify the school nurse immediately.

If you have any questions about the school tuberculin testing program, please contact the school nurse.

_____
(Signature of Principal)

_____
(School Nurse) (Phone)

Sample Letter

PARENT NOTIFICATION OF A SIGNIFICANT TUBERCULIN REACTION

Pupil's Name _____ Date _____

Dear Parent or Guardian:

In the recent tuberculin skin testing program at school, your child showed a significant reaction. This means that your child has apparently been exposed at some time in his or her life, to the germs which cause tuberculosis.

Please have your child examined by a doctor within the next two weeks. Ask the doctor to complete the form at the bottom of this page, and return it to the School Nurse.

Sincerely,

_____
(School Physician)

_____ Phone: _____
School Nurse

* *

NAME _____ Born _____ Sex _____
Last, First, Initial Mo., Day, Year

Address _____ Grade ____

_____

Medical Report

A chest X-Ray was administered on _____ and was

[ ] NORMAL
[ ] Compatible with tuberculosis

Isoniazid (INH) preventive therapy with a single daily dose of _____ mg was prescribed.

_____ _____
PHYSICIAN'S NAME (Please print or type) License Number

_____
SIGNATURE

Sample Letter

PHYSICIAN NOTIFICATION OF A SIGNIFICANT TUBERCULIN REACTION

Pupil's Name _____ Date _____

Dear Doctor:

Your name has been given as the physician for the pupil named above, who had a significant reaction of _____mm of induration to the Mantoux tuberculin skin test with 5 TU, at _____ School.

The rules of the State Department of Education require a chest X-ray if the Mantoux test shows 10 mm or more of induration.

If the chest X-ray is negative for evidence of current disease, it is recommended that the tuberculin reactor child receive one year of preventive treatment with isoniazid (INH) in a dosage of 10 mg/kg daily not to exceed 300 mg per day. It is recommended that the INH be given in a single daily dose. The use of larger dosages or for a longer period of time does not result in greater benefits. A person with a significant tuberculin reaction has a lifelong risk of developing tuberculosis disease. Protection for many years, and possibly for life, can be obtained by providing the child with one year of INH now.

Please notify the school health service of your findings, and decision concerning INH preventive therapy, at your earliest convenience. The child's parent or guardian has been asked to give you a form to be completed and returned to the school nurse. If the form is not returned within two weeks, the child will be referred to an appropriate clinic.

If you would like further information regarding the administration of INH, monthly monitoring, possible side effects, etc., please contact Communicable Diseases Operations Program (TB), New Jersey State Department of Health, CN 360, Trenton, New Jersey 08625, phone 609-292-7100.

Name of Agency (School, institution, other)

District | County

TB-42 Apr. 83 H2768

NEW JERSEY STATE DEPARTMENT OF EDUCATION
NEW JERSEY STATE DEPARTMENT OF HEALTH

REPORT OF
SIGNIFICANT TUBERCULIN REACTIONS

DISTRIBUTION: Submit within one week after completion of the testing program.
WHITE – New Jersey State Department of Health
CN 360, Trenton, N.J. 08625
Tuberculosis Control Program
CANARY – Retained by Reporting Agency
PINK – Mail to Local Health Department or TB Control Agency

Name and address of persons tested 1. **LAST NAME**, first and middle initial 2. Number, street, municipality and zip code 3. If mailing address differs from residence, record both	Date of Birth			Sex		Grade	Employee	New Pupil or New Employee*		Mantoux Test (5 TU) Results				X-Ray		INH Preventive Therapy		CLINIC OR PHYSICIAN (Name and City)
										Date Read			Induration in mm					
	Mo.	Day	Yr.	M	F			Yes	No	Mo.	Day	Yr.		Pos.	Neg.	Yes	No	

54

55

*Check Yes if pupil is new to your school district or if an initial examination of employee or volunteer.

TB-57
APR. 83

NEW JERSEY STATE DEPARTMENT OF EDUCATION
CN 500, Trenton, N.J. 08625
NEW JERSEY STATE DEPARTMENT OF HEALTH
CN 360, Trenton, N.J. 08625
Tuberculosis Control Program

COUNTY _____

DISTRICT _____

SCHOOL(S) _____

_____

ANNUAL REPORT OF TUBERCULIN TESTING IN SCHOOLS

For the School Year Ending June 30, 19 ____

DATE SUBMITTED _____

SUBMIT IN JANUARY FOLLOWING THE FALL SCHOOL TUBERCULIN TESTING

	PUPILS						Volunteers	Teachers and Employees
	8th Grade	13-Yr-Olds*	New Pupils	Grades**				
I. Number of Pupils Enrolled								Number ♦ ♦ ♦
II. Number of Teachers and Employees								
III. Tuberculin Test Findings								
A. Total Tested This Year _____								
1. Significant Reactions _____								
2. Non-Reactors _____								
B. Total Mantoux Tested Elsewhere This Year & Transferred to School _____								
1. Significant Reactions _____								
2. Non-Reactors _____								
IV. X-Ray Findings								
A. Total Number with Newly Indentified Significant Tuberculin Reactions Who Were X-rayed This Year _____								
1. Negative X-rays _____								
2. Positive X-rays _____								
V. Preventive INH Therapy (New Reactors only)								
A. Prescribed _____								
B. Not Prescribed _____								
C. Unknown _____								
VI. Diagnosed Cases – TB								
A. Number *** _____								

Prepared by (School Physician or Nurse) Please Print	Telephone Number	Signature of Superintendent or Principal

H2766

* In special or ungraded classes.

** If other grades are tested, please specify.

*** Enter names on Form TB-57a found in the back of the Reference Guide for Physicians and Nurses and mail this (white) form to:

Tuberculosis Control Program
New Jersey State Department of Health

AUTHORIZATION FOR NURSES TO ADMINISTER TUBERCULIN TEST

The school nurse may administer the intradermal tuberculin test as specified in the following official statement approved by the State Board of Medical Examiners and the New Jersey Board of Nursing. (See N.J.A.C. 13:37-6.1)

> The administration of the intradermal tuberculin test is a recognized nursing procedure. Nurses may administer the intradermal tuberculin test as authorized by R.S. 45:9-21k in the absence of a physician provided:
>
> The nurse as required by law operates in each particular case under the specific direction of a regularly licensed physician. Compliance with this law is effected by the written directives of a regularly licensed physician to a nurse indicating the person or persons to whom the intradermal test is to be administered.
>
> The nurse has been carefully trained in the technique of administration and recording results.
>
> The nurse has been certified as qualified to administer the intradermal tuberculin test by the medical advisory board of a voluntary agency or the physician responsible for tuberculosis control activities in an official agency.
>
> Standing orders relating to the administration of the test and recording of results are provided by the physician authorizing the tuberculin test. Records of each test administered indicate the authorizing physician and are maintained by the agency responsible for the employment, supervision and direction of the nurse.
>
> Reactive tuberculin tests are reported immediately to the reactors' physician in order that indicated medical examination can be undertaken.

4. SCOLIOSIS SCREENING

DEFINITION AND RATIONALE: Scoliosis is a lateral curvature of the spine, most commonly detected during the adolescent growth period and it is estimated that between five and ten percent of school children have a curvature in varying degrees. However, only about two percent of these are significant. The effect of scoliosis depends upon its severity, how early it is detected, and how promptly it is treated.

The New Jersey Legislature has charged "every board of education shall provide for the yearly examination of every pupil between the ages of ten and eighteen for the condition known as scoliosis" (N.J.S.A. 18A:40-4.3).

The goal of a mass screening program mandated by this law is early identification since a curvature can often be controlled if it's detected early. Any pupil with scoliosis should be under the care and supervision of the family physician or an appropriate clinic. Referral to an orthopedist or orthopedic clinic may also be indicated.

IMPLEMENTATION: Consider the following activities to plan a succesesful scoliosis screening program.

- An orientation of school staff, parents and pupils, via lecturing and/or using audio visual materials.

- School physicians, nurses, physical education teachers and other school personnel who will be screening pupils should attend the workshops approved by the New Jersey Departments of Education and Health.

- Initial screening should be performed by a school physician, school nurse or physical education teacher who has attended a training session.

- Parents/guardians should be informed in a communication understandable to them that all pupils ages ten through eighteen will be screened (N.J.S.A. 18A:40-5). Any pupil shall be exempt from the examination upon the written request of a parent/guardian.

Screening Techniques

1. Pupil stands with exposed back to screener. Pupils should wear bathing suits or special gowns. Screener checks for the following:

    a. Unequal shoulder levels
    b. Symmetry of scapulae
    c. Symmetry of flanks
    d. Uneven or greater crease at one side of waist
    e. Unequal distance between body and the elbow when both arms are hanging straight down from shoulder.

2. Pupil faces screener and bends at a 90° at the waist, feet together, knees straight, and arms hanging in front with palms together. Screener may sit facing pupil to check the following:

a. Rib hump (one side of upper back higher than the other)
b. Hump in both upper and lower back
c. Levels of the back on both sides of the spine.

3. Pupil turns to side and bends, while screener checks asymmetry of both sides of the spine and looks for a smooth continuous curve of spine.

Standards for Referral: Clearly identified abnormalities as confirmed by the school nurse or school physician should be referred to the family physician immediately. Questionable curvatures should be rescreened by the school nurse and examined by the school physician before any referral is made to a parent/guardian. A determination may be made to re-examine the pupil's spine in three months before making the referral to the family.

Referral and Follow-Through: The parent/guardian of each pupil suspected of a problem should be notified in writing of the significance of the findings and of further evaluation by the appropriate family medical practitioner. Information about an appropriate practitioner or clinic should be made available upon request. Parental notification should include a form for the examining physician on which to record findings and make recommendations. This report should be returned to the school nurse.

When a diagnosis of scoliosis has been made, it is recommended that the school nurse register the child with Special Child Health Services, State Department of Health (609-292-5676), with parental permission. When treatment is recommended, the school nurse should provide supportive counseling to the pupil and his/her family, teacher and peers. Careful and thorough follow-through is necessary to insure a worthwhile program.

MONITORING: In order to determine the effectiveness and validity of a yearly examination for all pupils aged ten through eighteen, it is imperative for the school nurse to maintain accurate records. A form will be provided to report the number of pupils screened by age, the degree of curvature noted, and/or any other abnormality detected and the follow-through. The original copy should be forwarded to the Department of Health. The yellow copy should be for your files. Sample forms are provided on the following pages.

Sample Letter

PARENT NOTIFICATION OF SCOLIOSIS SCREENING

Dear Parent(s)/Guardian(s):

There will be a screening program for scoliosis for all pupils, ages ten through eighteen, as required by law beginning _____.

Scoliosis is defined as a condition of the spine in which the spine may curve to the left or right. It is most commonly found during the time of rapid growth and may progress if not treated. The purpose of the screening program is to recognize scoliosis in its earliest stages.

A pupil may be exempt from this examination if requested by the parent/guardian in writing.

You are invited to be present if you desire. However, you will need to complete the form below, so that you can be advised of the time to be present. Whether or not you are present, you will be informed of any suspect problem.

Thank you for your cooperation.

Sincerely,

_____
Principal

.....

_____
Name of Pupil

_____
Signature of Parent/Guardian

I wish to be present at the time of screening ____ Yes ____ No

Sample Letter

NOTIFICATION TO PARENT OF PUPIL WITH POSSIBLE SPINAL PROBLEM

_____
Date

Dear Parents:

On _____, we wrote to you explaining that we would be conducting a Spinal Screening Program to detect possible spinal problems in children. A trained examiner examined your child's spine and has recommended further evaluation by your family physician or pediatrician.

We would like to emphasize that it is important to have a complete examination to determine what kind of treatment is indicated.

If you do not have a physician, we suggest that you call your school nurse. She can assist you in making an appointment to receive proper follow-up and will give you information concerning services available for financial assistance if needed.

The enclosed form should be presented to your physician at the time of your child's examination with the request that it be completed and returned to the school nurse as soon as possible.

The importance of proper follow-up for this matter cannot be emphasized too much. Thank you for your cooperation which is essential.

Sincerely,

_____ SIGNATURE

_____ PHONE NUMBER

PHYSICIAN'S SCOLIOSIS REPORT 19 -19

Name_____ Birth Date _____ Age _____
Sex M__ F__

Parents_____ Address_____
_____ _____
School_____ Grade_____
County_____ Family Physician_____

HISTORY

Prior Awareness: No__ Yes__ How Long _____
Symptoms, Complaints_____

Family History of Scoliosis Yes _____ No _____
(If "yes", indicate relationship)

Remarks_____

Under Care Prior to Screening_____

X-RAY REPORT
(If X-ray is indicated)

Results 1. Negative ____
2. Scoliosis____

a. mild _____
b. moderate _____
c. severe _____

3. Kyphosis/Lordosis _____
4. Other _____

RECOMMENDATIONS

1. Discharged on _____ 2. Rescreen _____
Date Date

3. Repeat AP Standing X-Ray: _____
Date

4. Refer for Orthopedic Evaluation _____

_____ _____
Date Physician's Signature

New Jersey State Department of Education/Department of Health

ANNUAL SCOLIOSIS SCREENING REPORT 198__ - 198__

County Code _____ School(s) _____

District Code _____ (Use codes) _____

SECTION A							SECTION B (follow-up)							
			Screening Results											
Ages	Total Screened	Total Not Screened	Referral Old	Referral New	Question-able Not Referred	Number X-Rayed	Physician's Findings Mild	Moderate	Severe	Other	Treatment Brace	Surg.	Other	Dis-charge
10-14														
15-18														
TOTAL														

DIRECTIONS:

1. Complete Section A as soon as program has been completed.

2. The Number Not Screened should represent those pupils for whom a parental request to omit screening was received.

3. Old means previously identified.
   New means identified through this screening.
   Questionable indicates pupil will be watched and screening again within three months.

4. Section B contains the follow-up of the screening program and can be completed from the responses from parents and physicians.

5. Complete and return by _____.

   Mail original copy to:

   N.J. State Department of Health
   Community Health Services
   Special Child Health Services
   CN 364, Trenton, New Jersey 08625

   Retain yellow copy for your files.

School Nurse Date School Administrator

5. VISION SCREENING

DEFINITION AND RATIONALE: A student's vision is directly related to his/her academic performance and overall ability to adjust to school. Pupils who cannot see well miss important aspects of their educational experience that they may never be able to recapture or repeat. While some visual problems are readily apparent, others can be detected only through careful vision screening.

Ideally, all students should have a professional eye examination prior to entering school as part of their total health assessment. This is, however, not always done. A comprehensive school eye program includes planning, observation, screening procedures, referral and follow-up.

IMPLEMENTATION: Teacher observations that should be considered significant include: crossed eye, cast in eye, frowning, excessive blinking, squinting, rubbing, redness of eyes or eyelids, frequent headaches, inability to read the blackboard, and/or other reading difficulties and academic problems.

Pupils should be informed of the purpose of vision screening and the methods to be used, as well as the importance of correcting any deviations. The nurse can take this opportunity to explain how the eyes function, the relationship of light to sight and other grade level appropriate concepts.

An actual demonstration of vision screening for very young children is important. The Children's Eye Health Guide, prepared by the National Society to Prevent Blindness, recommends that pupils be tested at the following ages:

- Preschool (3 or 4 year olds)
- Kindergarten (or first grade, 5 or 6 years)
- Second grade (7 years)
- Fifth grade (10 or 11 years)
- Eighth grade (13/14 years)
- Tenth or Eleventh grades (15/17 years)

In addition the following students also should be screened:

- All new pupils
- All pupils registering for driver education
- All teacher-referred children who show signs or symptoms of visual problems; experience scholastic failure; and/or have reading difficulties or other learning problems (dyslexia among them)
- All children at high risk of having vision disorders i.e., special needs and handicapped children
- All children referred to child study team for evaluation

VISUAL EXAMINATIONS: There are five visual functions which may be assessed in a screening: a) distance visual acuity; b) near vision; c) muscle balance; d) stereopsis; and e) color discrimination.

The following instruments are in common use:

1. Snellen E Chart (Preschool and Grade 1)
2. Snellen Letter Chart (Grades 2-12)

3. Snellen Lighted Chart
4. Massachusetts Vision Kit
5. Atlantic City Vision Test
6. Titmus School Vision Tester NOTE: NSPB does not recommend machine testing for preschool children because observation of the child is very important at this age.
7. Orthorater
8. Telebinocular

Routine administration of a battery of tests to all children is discouraged for a number of reasons. First, other tests are not accurate for children who have failed the distance visual acuity test. It is not necessary to fail a child by more than one test; multiple problems may be discovered during a professional eye exam.

Distance Acuity: The ability to see symbols at a measured distance of 10 or 20 feet or the equivalent is considered by many authorities to be the most important single vision test. It identifies more children who require eye care than any other single test. The combination of the teacher's (or nurse's) observation with the Snellen test has been found to have a high correlation with clinical findings by ophthalmologists.

The Snellen Chart is an inexpensive, easy-to-administer test that requires little time per pupil. It is considered the basic minimum for a vision screening program. The state does not mandate any specific equipment to be used for screening purposes; this is a local district decision.

The use of the Snellen Letter Chart for grades 2-12, and the Snellen E Chart for preschool and grade 1 children and children in other grades who do not know the alphabet or have special learning problems is recommended. These two instruments are in common use. Criteria for referral after these examinations suggested by the National Society to Prevent Blindness are given below.

NATIONAL SOCIETY TO PREVENT BLINDNESS
SCREENING REFERRAL CRITERIA FOR PROFESSIONAL EXAM*

VISUAL ACUITY TEST - (SNELLEN)

- **3-Year Olds** 20/50 or poorer in either eye (the inability to identify correctly one more than half the symbols on the 40-foot line at 20 feet). (10/25 on a 10-foot chart).
- **3-Year Olds** A two-line difference between the eyes in the passing range, i.e., 20/20 in one eye and 20/40 in the other.
- **4-Year Olds and Older** 20/40 or poorer in either eye (the inability to identify correctly one more than half the symbols on the 30-foot line at 20 feet). (10/15 on a 10-foot chart).

* 20/20 for children of all ages is considered excellent. However, visual acuity of 20/40 is a PRACTICAL referral level.

Alternative tests are useful in checking the distance vision of children who would otherwise be untestable, i.e., the mentally retarded, those with poor directional sense, etc. However the validity and the reliability of these alternative test results may not be as good as with the Snellen E. They include:

1. HOTV or Matching Symbol Test (can be used with persons of a mental age of three)
2. Faye Symbol Chart
3. Allen Picture Card Test

Children who fail the distance visual acuity test or any other test should be rescreened before referral.

SCREENING PROCEDURES USING OTHER VISION TESTS: The vision tests outlined below should be administered only after the distance visual acuity test and follow-up have been completed.

- **Plus Lens for Excessive Hyperopia Near Vision**: Pupil is positioned twenty feet from Snellen Chart with both eyes open wearing appropriate diopter plus lenses. If using other than a Snellen Chart, follow the procedure for that specific testing equipment.

- **Hirschberg Test (Muscle Balance Test)**: This test estimates the corneal light reflex from the center of the pupil of the eye. A small fixation light is held at eye level, 30cm from pupil's eye. A normal response shows the light in a similar spot on the pupil of each eye. Deviations indicating muscle imbalance are shown by the unequal positions of the light reflex on the pupil of each eye.

- **The Alternative Cover Test (Muscle Balance Test)**: This test observes the eye movements when each eye is alternately covered and uncovered. The pupil is requested to look at a fixed or primary target at 14 inches for two seconds. The eye cover card is moved and movements in the uncovered eye are observed. The Cover-Uncover Test will reveal whether

or not there is a transition from monocular to binocular vision. The Uncover-Cover Test will reveal whether or not the eyes can move from binocular to monocular vision.

- **Worth Four Dot Test (Stereopsis)**: A clinical test for fusion or binocular cooperation. The pupil views a flashlight on which four lights (two green, one red, one white) are mounted wearing a pair of red and green goggles. When the red lens covers the right eye, that eye sees only the red light in the flashlight; the eye covered by the green lens sees only green. Both eyes see the white light which may be reported as either red or green. The test will reveal suppression in either eye depending on the responses of the pupil. The red lights will indicate suppression in the right eye, five lights will indicate diplopia. With both eyes open, any response other than four lights is considered failure.

- **Color Perception**: Pupils entering kindergarten or first grade should be able to identify primary and secondary colored yarn or paper. Sixth grade pupils should be tested with peudoisochromatic plates following the manufacturer's directions. All color testing should be done in natural daylight or special artificial illumination simulating daylight as opposed to indirect light. Parents, teachers and pupils need to be made aware of color vision deficiencies, and it is particularly important to amass this information before pupils make vocational choices.

SYMPTOMS FOR REFERRAL WITHOUT SCREENING: Pupils observed by the teacher, nurse or screener as having or complaining about any of the following symptoms should be referred directly to the family physician or pediatrician for evaluation and decision as to the need for referral to an ophthalmologist regardless of screening results.

1. Crusts on lids among lashes
2. Red eyelids
3. Recurring styes or swollen lids
4. Complaints of itchy, burning, or scratchy eyes
5. Thrusting head forward
6. Tilting head
7. Watery eyes
8. Frowning, scowling, or squinting
9. Puckering the face
10. Closing one eye during test of both eyes together
11. Excessive blinking
12. Crossed eyes

FOLLOW-UP: Careful follow-up of referrals is essential to assure that pupils are examined by the appropriate eye care practitioner and receive treatment if prescribed. If the pupils referred do not receive professional attention, the vision screening program has failed to achieve its goal.

OTHER FACTORS TO CONSIDER: While vision screening is extremely important at all ages, preschool children who have undetected visual problems can miss out on many of the experiences important to perceptual and cognitive development. They may have poor visual discrimination which will interfere with reading ability. Amblyopia or lazy eye unless discovered and treated at an early age will result in some loss of sight. Therefore, preschool screening should be encouraged in all day care centers, nursery schools and preschool programs.

6. BLOOD PRESSURE SCREENING

DEFINITION AND RATIONALE: Hypertension is a significant public health problem in the United States, the prevalence rates of which vary according to age, race, nutrition, environmental stresses, and certain physical health problems. Hypertension usually begins insidiously, seldom producing symptoms until it is well established. It may even be asymptomatic.

The goal of a school blood pressure screening program should be early identification of pupils with consistently elevated blood pressure, and the appropriate follow-through. An educational component can include understanding the procedure, the equipment used, the normal range, the significance of an elevation in blood pressure, the factors which affect blood pressure, and the importance of prevention and/or treatment.

Blood pressure screening should be included as part of the physical examination as designated in the rules of the New Jersey State Board of Education and may be performed by one of the school health services specialists.

IMPLEMENTATION: The equipment needed for this screening procedure includes a mercury or aneroid manometer, a compression cuff and a stethoscope. A mecury type manometer is more reliable and accurate; causes of error can be determined visually. The instrument must be kept clean, its glass tube free of dust, and the mercury reservoir properly filled. While the aneroid manometer is less bulky, it requires more frequent calibration than a mercury manometer. Compression cuff(s) must be suitable to the age

of pupils/staff. The cuff must cover 2/3 of the length of the upper arm and the rubber bladder should encircle its girth. The stethoscope should be regularly checked to see that the earpiece is clean and that the diaphragm is intact.

Dimensions for Appropriate Size Cuff*

Name	Width (cm)	Length (cm)
Newborn	2.5 - 4.0	5.0 - 10.0
Infant	6.0 - 8.0	12.0 - 13.5
**Child	9.0 - 10.0	17.0 - 22.5
**Adult	12.0 - 13.0	22.0 - 23.5
**Large Adult	15.5	30.0
Adult thigh	18.0	36.0

*"Report of the Task Force on Blood Pressure Control," Pediatrics, 59(5): Part 2, May 1977.
**It is suggested these sizes be available for school use.

SCREENING TECHNIQUES: Steps for screening are described below:

1. Explain what blood pressure is, the importance of knowing about it, and the overall procedure in terms the pupil can understand.

2. Seat the child to be screened with the forearm suitably bared, flexed, and resting on a table so that the cuff will be placed at the level of the right atrium. The dial of the aneroid or mercury column should be placed so it can be read at eye level.

3. Apply the appropriate size cuff with the center of the rubber bladder over the brachial artery leaving a space of about 1 cm between the bottom of the cuff and the antecubital area.

4. Locate the radial artery pulse by palpation and inflate the cuff to about 30mm Hg above the pressure at which the radial pulse disappears. Then deflate the cuff at a rate of approximately 2 mm Hg/second. Note the level at which the radial pulse returns. Deflate cuff and wait 15 seconds.

5. Locate the brachial artery pulse by palpation, place the diaphragm of the stethoscope over the artery. Rapidly inflate the cuff to a pressure approximately 30mm Hg level at which the radial pulse was identified in #4 above. Deflate the cuff gradually (2 mm/sec) until the first clear tapping sound is heard (Korotkoff Sound, Phase I). Record this point as the systolic pressure. Continue to deflate the cuff while the sound becomes clearer, louder, and crisper, then suddenly changes to a low-pitched muffled one (Phase IV), then disappears (Phase V). Record Phases IV and V. Use Phase IV, the point at which the sound changes, as the standard for referral (e.g. 120/80/60).

6. Repeat the auscultation method (#5 above) to assure accuracy and allow the pupil time to relax as the procedure becomes familiar. Check your recording.

7. Inform the pupil of your findings and the nature of any referral or follow-up that may be necessary. Allow the pupil time to ask questions.

8. Normal blood pressure ranges are as follows:

6 years and under	78/48 - 114/80
7-9 years	82/52 - 120/80
10-12 years	90/58 - 134/84
13-49 years	90/60 - 140/90
50 years and older	90/60 - 160/95

STANDARDS FOR REFERRAL: If either the systolic or diastolic reading is higher than the above levels, allow pupil to rest about 15 minutes then recheck. If the readings are still higher than the chart levels, recheck on another day. Diastolic pressure of 100 mm Hg or above should be confirmed and referred for prompt medical evaluation. A pupil with systolic or diastolic pressure above the normal range should have referral made to parent/guardian. Assistance should be offered if parent/guardian needs help in obtaining medical follow-up. Group counselling might be effective if there are a number of pupils on the secondary level with blood pressure variations.

CONTINUED MONITORING: Continued monitoring should be provided if requested by the family physician. In some instances medication may be prescribed and the nurse should be available to administer and monitor such medication in accordance with the state and local school board policy. If adaptation of the school program is recommended, the nurse can facilitate this action. At least annually, all pupils with blood pressure variations should be rescreened for follow-up. Severity of the problem may indicate that more frequent checks are necessary.

SD/lp:1/1530j & 1516j

CHAPTER III

PUBLIC HEALTH SUPERVISION

1. IMMUNIZATION MONITORING

Uniform immunization has been mandated through New Jersey State Sanitary Code, Chapter 14 (N.J.A.C. 8:57-4.1 to 8:57-4.16). These regulations are promulgated by the New Jersey State Department of Health. Yearly updates are made available to chief school administrators from that department. A copy of the regulations in effect at the time of this printing follows:

Regulation 1 - Applicability

These regulations shall apply to all pupils attending any public or private school in New Jersey, including child care centers, nursery schools and kindergartens, except that the regulations shall not apply to pupils under one year of age.

Regulation 2 - Proof of Immunization

No principal or other person in charge of a school shall knowingly admit or retain any pupil who has not submitted acceptable evidence of immunization according to the schedule specified below, except when there are exemptions as noted in this Chapter.

Regulation 3 - Immunizations Which Are Medically Contraindicated

a. A pupil shall not be required to have any immunizations which are medically contraindicated.

b. A written statement from any physician licensed to practice medicine or osteopathy in any jurisdiction in the United States stating that an immunization is medically contraindicated for a specified period of time, and the reasons for the medical contraindication, will exempt a pupil from the specific immunization requirements of this Chapter for the period of time specified in the physician's statement.

c. The physician's statement shall be maintained by the school as part of the immunization record of the pupil.

Regulation 4 - Exemptions; Parent or Guardian

a. A pupil shall be exempted from mandatory immunization if the parent or guardian of the pupil objects thereto in a written statement signed by the parent or guardian upon the ground that the proposed immunization interferes with the free exercise of the pupil's religious rights.

b. This statement will be kept by the school as part of the pupil's immunization record.

c. This exemption may be suspended by the State Commissioner of Health during the existence of an emergency as determined by the State Commissioner of Health.

Regulation 5 - Provisional Admission to School

a. A pupil may be admitted to school on a provisional basis if a physician or health department indicates that immunization of the pupil has already been initiated and that the pupil is in the process of complying with all immunization requirements.

b. Such provisional admission shall be a reasonable length of time that is consistent with the immunization schedule set forth in Sections 10, 11, 12, 13 and 15 of this Chapter but shall not exceed one year of completion of all immunization requirements.

Regulation 6 - Documents Accepted as Evidence of Immunization

a. The following documents will be accepted as evidence of a pupil's immunization history provided that the individual immunizations and the date when each immunization was administered are listed:

1) An official school record from any school indicating compliance with the immunization requirements of this Chapter

2) A record from any public health department indicating compliance with the immunization requirements of this Chapter

3) A certificate signed by a physician licensed to practice medicine or osteopathy in any jurisdiction in the United States indicating compliance with the immunization requirements of this Chapter

4) For pupils seven years of age or over, a written statement from a parent or guardian of a pupil indicating compliance with the immunization requirements of this Chapter will be acceptable only for the academic year 1975-1976. These statements, when entered into official school immunization records, shall be considered as adequate evidence of immunization throughout the remaining years of school attendance of such pupil.

Regulation 7 - Records Required

a. Every school shall maintain a record of immunization for every pupil which shall include the date of each individual immunization.

b. A standard record of immunization shall hereafter be maintained by every school on forms supplied by the State Department of Health or Education for all new school entrants under seven years of age and for pupils of all ages transferring from out-of-state schools.

c. If a pupil transfers to another school, this original record shall be sent to the new school by the original school.

Regulation 8 - Reports to be Sent to State Department of Health

a. A report of the immunization status of the pupils in every school shall be sent each year to the State Department of Health by the principal or other person in charge of a school.

b. The form for the report shall be provided by the State Department of Health.

c. A copy of this report shall be sent to the local board of health in whose jurisdiction the school is located.

Regulation 9 - Records Available for Inspection

The principal or other person in charge of a school shall make immunization records available for inspection by authorized representatives of the State Department of Health or the local board of health in whose jurisdiction the school is located.

Regulation 10 - Diphtheria and Tetanus Toxoids and Pertussis Vaccine

Every pupil shall have received four doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP), and the last dose shall be administered not less than six months after the previous dose, except that pupils after the seventh birthday who have not completed these requirements shall have received tetanus and diphtheria toxoids, adult type (Td) instead of DTP. For pupils after the seventh birthday who have not completed these requirements, any combination of three doses of either DPT or Td, provided that the last dose was administered not less than six months after the preceding dose, shall be acceptable as adequate immunization with this vaccines series. Pupils who have not received any vaccines containing tetanus toxoid in ten years shall receive a booster dose of tetanus and diphtheria toxoids, adult type (Td).

NOTE: Amended effective January 4, 1982

Regulation 11 - Poliomyelitis Vaccine

a. Every pupil shall have received at least three doses of poliomyelitis vaccine, live, oral, trivalent and the last dose must have been administered not less than six months after the previous dose.

b. If a pupil has received poliomyelitis vaccine, live, oral, type one; poliomyelitis vaccine, live, oral, type two; and poliomyelitis, live, oral, type three; this will be accepted in lieu of the first two doses of poliomyelitis vaccine, live, oral trivalent.

c. If a pupil has received four doses of inactivated poliomyelitis vaccine, this will be accepted in lieu of oral poliomyelitis vaccine, provided that the last dose must be administered not less than six months after the previous dose, and that all of the inactivated poliomyelitis vaccine was received in 1968 or thereafter.

Regulation 12 - Measles Virus Vaccine

a. Every pupil shall have received one dose of measles virus vaccine, live, attenuated, or any vaccine combination containing measles virus vaccine, live, attenuated, administered after one year of age.

b. Pupils receiving measles vaccine prior to one year of age shall be revaccinated.

c. Pupils with a history of having had the disease measles as certified by a physician licensed to practice medicine or osteopathy in any jurisdiction of the United States, or pupils who present laboratory evidence of measles immunity shall not be required to receive measles vaccine.

NOTE: Amended effective September 1, 1982

Regulation 13 - Rubella Vaccine

a. Every pupil shall have received one dose of rubella virus vaccine, live, or any vaccine combination containing rubella virus vaccine, live.

b. Rubella virus vaccine, live, shall not be required in pupils who present laboratory evidence of rubella immunity.

NOTE: Amended effective September 1, 1982

Regulation 14 - Providing Immunization

a. A board of education and/or a local board of health may provide, at public expense, the necessary requirement, materials and services for immunizing pupils with the following immunizing agents, either singly or in combination:

1) Diphtheria toxoid
2) Pertussis vaccine
3) Tetanus toxoid
4) Measles virus vaccine, live, attenuated
5) Rubella virus vaccine, live
6) Poliomyelitis vaccine
7) Mumps virus vaccine, live
8) Other immunizing agents when specifically authorized to do so by the State Department of Health

Regulation 15 - Mumps Vaccine

a. Every pupil, born on or after January 1, 1973, shall have received mumps virus vaccine, live, or any vaccine combination containing mumps vaccine, live. (Amended effective June 3, 1985)

b. Pupils with a history of having had the disease mumps shall not be required to receive mumps vaccine.

Regulation 16 - Disease Outbreak Control

a. In the event the Commissioner of Health determines that an outbreak or threatened outbreak of disease or another public health immunization emergency exists, the Commissioner may issue either additional immunization requirements to control the outbreak or threat of an outbreak or amend requirements to meet the emergency.

b. All pupils failing to meet these additional requirements shall be excluded from school.

c. These requirements or amendments to the requirements shall remain in effect until such time the State Commissioner of Health determines that an outbreak or a threatened outbreak no longer exists or the emergency is declared over, or for three months after the declaration of the emergency, whichever one comes first. The State Commissioner of Health may redeclare a state of emergency if the emergency has not ended.

NOTE: Amended March 25, 1985

Records and Reporting

Recording of all immunization shall be done on the Health History and Appraisal Card, A-45, (Rev 3/79). This requirement applies to all pupils entering September 1979 and thereafter. A copy of this was presented earlier in this document. The Immunization Status Report, VA-20, must be completed and forwarded to the appropriate official health agency by December 1 of each year. The form comes to the local district from the New Jersey State Department of Health. Questions regarding immunization should be directed to the Immunization Control Office, New Jersey Department of Health (609-292-5635) or East Orange (201-266-1910).

2. OBSERVATION OF PUPILS WITH COMMUNICABLE DISEASES

While most childhood communicable diseases are disappearing as a result of mandatory immunization, it may be helpful to be able to observe and recognize the following:

Measles Red, raised papules begin on the exposed parts of the body (face, arms) and spread. Itching is present. First symptoms often are coryza, fever, or tiredness. Small white spots on a red base, Koplik spots, may appear in the mouth. Usually lasts one to two weeks. Transmission by direct contact; communicable from five days before appearance of rash to four days after. Atypical measles may be manifested in flu-like symptoms and joint pain and swelling.

Rubella A virus-caused illness with mild symptoms. It is primarily significant however, because of the congenital defects it can cause when an expectant mother is exposed to it during her first trimester of pregnancy. First symptoms are swollen glands, either behind the ears or at nape of neck, followed by a blotchy, red rash appearing first on the face and then spreading to the trunk, biceps and thighs. Fever may or may not be present. Occasionally there may be swelling in small joints of fingers. It is transmitted through nasopharyngeal secretions; communicable from seven days before appearance of rash to four days after.

Chickenpox Usually begins as an acute illness with fever, fatigue and a skin eruption that starts as papules, then vesiculates for three or four days and leaves a scab. Lesions are more prevalent on the covered parts of

the body, but may occur on scalp and mucous membranes of the mouth. Transmission is usually by droplet although it may be spread by fomites. Communicable from five days before rash until lesions become dry, or not more than six days after last crop of vesicles.

Mumps A viral disease that attacks the salivary glands at the angle of the jaw. Headache, fever and mild respiratory symptoms usually are present. In post-pubertal individuals, the gonads may become infected and painful. The central nervous system may be involved and cause increased irritability. Transmission is by direct contact or droplet spread from saliva. Communicable from six days before swelling to nine days after swelling appears.

Common Cold Characterized by sneezing and watery discharge from nose and eyes. Throat may be irritated and temperature slightly elevated. Coughing and chill may be present. Transmission by direct contact of airborne droplets or articles freshly soiled by discharge from mucous membranes. Communicable 24 hours before to five days after onset.

Conjunctivitis Characterized by redness, swelling, burning or itching of eye membranes. May have sensitivity to light and a yellow discharge. Transmission through direct contact. Communicable first 24 to 72 hours and until discharge has ceased.

Hepatitis Is generally classified as Hepatitis A (formerly Infectious Hepatitis) and Hepatitis B (formerly Serum Hepatitis).

- **Hepatitis A** - An abrupt onset of malaise, loss of appetite, low-grade fever, nausea, abdominal pain, gastrointestinal upset and, in some cases, jaundice. Transmission is the fecal-oral route. Communicable 14 days before to about seven days after the onset of jaundice. Some cases remain in a carrier state.

- **Hepatitis B** - Symptoms are similar to those for Hepatitis A but may be milder or much more severe with occasional arthralgia. When jaundice is not present, the peak of infectivity can be determined only through a blood test. Transmission occurs from infected blood via transfusion, direct contact with blood or blood products, or intimate contact with oral secretion or semen. Communicable many weeks prior to symptoms, throughout the course of illness and, in some cases, into a carrier state. ISOLATION PRECAUTIONS: Normal school contact poses no risk of transmission to other persons even when the index case is a chronic carrier.

Mononucleosis An infectious disease characterized by a fever which increases daily, anorexia, malaise and sore throat. Enlargement of the cervical glands may become apparent. There may also be a maculopapular rash and mild jaundice. Transmitted by direct contact. ISOLATION PRECAUTIONS: Exclusion from school is not necessary.

Streptococcal Sore Throat This is a sore throat with or without a fever and may involve the cervical lymph nodes. It is caused by the group A, beta hemolytic streptococcus. A rash may appear on neck, chest, groin, and axilla in which case a diagnosis of Scarlet Fever may be made. Transmitted

by direct contact or airborne droplets. Communicable, if untreated, for several weeks. If treated, communicable for less than 24 hours. Any sore throat infection may be caused by the streptococcal organism. A strep throat infection may cause rheumatic fever which can lead to permanent heart damage or acute glomerulonephritis. The only way to make a positive diagnosis is through a throat culture. The latex agglutinction test is a diagnostic test for streptococcal sore throat. ISOLATION PRECAUTIONS: Exclusion from school for 24 hours after beginning antibiotic therapy.

School districts who wish to provide a **Strep Control Program** should have nurse(s) trained in the principles and techniques of strep disease control. The State Laboratory of the New Jersey State Department of Health (609-324-6055) trains school nurses and provides school districts with information regarding various program options.

Sexually Transmitted Diseases (STD)

- **Gonorrhea** - A bacterial infection caused by gonococcus. In males there is a purulent discharge from urethra two to nine days after exposure. Discharge may subside but infection may cause inflammation of the epididymus and prostate gland. Asymptomatic cases have also been reported. Young children with genital or pharyngeal gonorrhea should be evaluated for possible child abuse.

In females it is manifested by urethritis or cervicitis. If untreated, can lead to salpingitis or pelvic peritonitis, which may become chronic. Transmitted via sexual activity. Communicable until treated.

In young children this is occasionally seen in the form of conjunctivitis. This is primarily a problem in young infants 0-4 weeks of age and requires hospitalization and treatment.

- **Syphilis** - A bacterial disease caused by the spirochete. Characterized by a primary lesion or chancre (occasionally no chancre occurs); secondary stage, by eruption involving skin and mucous membranes; and tertiary stage, with neurological, cardiovascular, skin and bone lesions. During secondary stage, blood tests will always be positive.

  Transmission via sexual activity. Communicable throughout primary and secondary stages unless treated. Infectivity ends with appropriate treatment in 24 hours.

  There are other diseases which are sexually transmitted including Herpes simplex, Trichomonas, candidiasis, hepatitis, AIDS and Chlamydia.

Nuisance Diseases Other communicable conditions that the nurse should be able to recognize are the "so-called" nuisance diseases. They inlcude:

- **Scabies** A skin infestation caused by burrowing itch mite (Sarcoptes scabiei). It is characterized by itching, especially at night, and blister-like sores in burrows on the skin. Usually prevalent between fingers, heels and palms, wrists, armpits, buttocks, genitalia and elbows. Transmissions is by direct contact. All members of a household should be treated for infection. Communicable until mites and eggs are destroyed. ISOLATION PRECAUTIONS: Exclusion from school is necessary until the day after treatment.

- **Impetigo** A skin eruption caused by the staphylococcus or streptococcus organism that may proceed through vesicular, pustular and encrusted stages. Transmission by direct contact. Refer for immediate treatment. ISOLATION PRECAUTIONS: Child should not return to school until 24 hours after beginning antimicrobial therapy.

- **Pediculosis** An infestation of the hair or hairy parts of the body. Lice deposit larvae or nits on the scalp at the base of the hair follicles which cling to the strands of hair. The distance from the scalp usually indicates the length of infestation based on the hair growth. Eggs hatch in seven days and the resultant lice are capable of reproducing in two weeks. Itching may be the first sign noted. Transmitted by direct contact or fomites coming in contact with an infected person. Communicable until lice and eggs are destroyed. ISOLATION PRECAUTIONS: Children should be allowed to return to school the morning after their first treatment.

- **Ringworm** A fungus that may occur on the body, in which case it is called tinea corporis, or on the scalp and is called tinea capitis. It begins as a small papule which spreads outward and appears as a red, scaly outer ring with a clear center. The lesions are itchy and can become infected with excessive scratching. Transmission is by direct contact with human or animal source. ISOLATION PRECAUTIONS: Tinea capitis - exclusion from school until therapy is initiated. Tinea corporis - no isolation precautions are necessary. Periodic inspection of contacts is recommended.

- **Athlete's Foot** This is a superficial fungal infection (tineapedis) widely spread through the use of showers, swimming pools, common bath mats or direct contact with an infected person. Characterized by peeling, cracking and itching of skin between the toes. May spread to hands, groin and other parts of the body. Prevention involves specific hygienic measures around showers, swimming pools, and instruction in fact care and preventive measures. ISOLATION PRECAUTIONS: Isolation is not practical. Treatment of patients with active infections should reduce transmission. Chemical foot baths are of no value and may actually facilitate spread of infection.

3. FIRST AID AND EMERGENCY CARE

New Jersey regulations, (N.J.A.C. 6:29-2.3), require district boards of education to adopt rules and procedures for the care of pupils suddenly taken ill or injured at school and that such rules and procedures be explained at the beginning of each school year to all employees. Copies of the rules and procedures should be posted in each school at points conveniently accessible to the personnel (e.g., office, cafeteria, gymnasium, school buses, shops and similar work areas). These procedures should be developed through the cooperative efforts of the school physician, the school nurse, and the school administrator, and provide for immediate and necessary care to an individual who is suddenly taken ill or injured. Notification of appropriate school authorities and the parent/guardian, as well as the mode of transportation and escort for the injured party, should also be included.

Procedures: Specifically, these procedures should include the following information or procedures:

1. Persons qualified in first aid should be designated by the administrator in the order in which they should be called if the school nurse is unavailable.

2. A current, readily accessible emergency file card for each child/family which includes:

   - Home and business addresses and telephone numbers of each parent/guardian and two other adults who would assume temporary responsibility in emergency situations.

- Name, address and telephone number of family physician and/or clinic facility.
- Name and telephone number of hospital of choice.
- Medical information such as chronic disease conditions, medication being taken and allergies.

A similar emergency card should be completed for all employees.

3. In the administrative office, health office, physical education office and any strategic place where there is a telephone, the name, address and telephone number of the following services should be clearly posted:

- Rescue squad or ambulance service
- Police department
- Nearest hospital
- Poison control center (1-800-962-1253)
- School physician
- Division of Youth and Family Services
- Child and Sexual Abuse Center

4. In cases of extreme emergency, when school personnel are unable to reach parent/guardian or other person(s) designated by the parent as indicated on the emergency card, the school, acting in the place of the parent, is responsible for transporting the child to the source of medical attention. Policy regarding transportation of students should be addressed by the local board of education as part of their emergency medical procedures.

5. If an ambulance is needed, the following procedures should be followed:

   - Have a responsible person place the call.
   - Give specific direction to the ambulance dispatcher as to location of ill or injured. (Perhaps a guide can be available.)
   - Give dispatcher the name of ill or injured and the reason ambulance is being requested, thus assuring adequate manpower and appropriate equipment.

6. To insure accuracy in detail, after an accident occurs and emergency care is given, a report should be completed by the person(s) observing the accident and rendering first aid. Essential information should include: date, time of day, place, description of accident and injury, witnesses, type of first aid administered, means of transportation and the time parent/guardian was notified.

7. First aid supplies in kits should be properly stocked in accord with the area serviced, and periodically checked by the school nurse to insure adequate supply. First aid kits should be located in the following areas: shops, home economics rooms, science labs, cafeteria, gymnasium, school buses and athletic field. Those supplies deemed necessary in relation to the areas serviced should be included.

8. In-service first aid procedure training should be available to all adult members of the school community. The school physician and/or school nurse should provide such first aid as well as CPR instruction to members of the school staff not already accredited by Red Cross or EMT services. Updating should be provided as needed. Health education classes at each grade level should include appropriate first aid information.

Standing Orders: All health personnel are expected to follow and implement emergency procedures that are written and/or reviewed and annually signed and dated by the school physician. It is suggested standing orders be made available for at least the following conditions:

Abdominal cramps, dysmenorrhea
Bite - human, animal, insect
Burns - heat (including sunburn, chemical)
Cessation of breathing
Convulsions, seizures
Dermatitis, ivy, sumac, oak
Diabetic conditions - shock, coma
Drowning
Drug abuse or intoxication (including alcohol intoxication)
Ears - foreign body, pain
Eyes - foreign body, burns, conjunctivitis, injuries
Fractures - extremities
Frostbite
Headache - mild, severe
Heat exhaustion/heat stroke
Injuries - head/spine/neck, compound fractures, sprains/strains
Nausea/vomiting
Poisoning - by mouth
Shock - anaphylactic, diabetic
Skin eruptions - infections/rashes, impetigo, ringworm, scabies
Splinters
Toothache and dental injuries
Wounds - abrasions
avulsions
contusions
incisions
lacerations
punctures
severe bleeding

4. ADMINISTRATION OF MEDICATION

One of the critical issues in school health services today is the administration of medication in both the public and nonpublic schools throughout New Jersey. For a number of years, school personnel have had serious concerns regarding the legality of and procedures for administering medication within the school district.

The administration of medication by school personnel should be discouraged as it is not normally a function of education. Some children with chronic illnesses and specific disabilities, however, often require medication during the course of the school day.

In September 1981, the Commissioner of Education ruled in the Bernards Township Education Association et.al. v. Board of Education of Bernards Township, 1981 S.L.D. 1070, aff'd State Board 1982 S.L.D. 1443 that only a certified school nurse could administer medication. Therefore, it is important that local boards of education develop a policy for the management of medication. The following information is being provided to assist local district boards of education in their efforts to develop such a policy.

GUIDELINES FOR THE ADMINISTRATION OF MEDICATIONS IN SCHOOLS: When the administration of medication in school is an issue, the following guidelines are recommended:

1. The parent or guardian should provide a written request for the administration of the prescribed medication at school.

2. Written orders are to be provided to the school from the private physician, detailing the diagnosis or type of illness involved, the name of drug, dosage and time of administration.

3. The medication should be brought to the school in the original container, appropriately labeled by the pharmacy or physician.

4. The school physician should review the orders of the private physician.

5. The school should provide a secured, locked space for the safe storage of medication, and prescription drugs should be kept locked at all times.

6. The certified school nurse or parent/guardian is the only one permitted to administer medication in the schools and/or on school trips.

7. The records or documentation process is required to be maintained by the school nurse.

CHAPTER IV

HEALTH SUPERVISION OF SCHOOL PERSONNEL

Because of their close and continuous interaction with one another and with pupils during the school day, the health of school personnel is extremely important. Moreover, the health and health habits of staff directly influence the health and attitudes of pupils. Good health is necessary for all members of the school staff including administrators, instructors, educational services staff, secretaries, bus drivers and maintenance personnel.

Prior to working in the district school employees should submit a complete health history and assessment. This appraisal can be given by the employee's personal physician or health maintenance organization and should be kept in a confidential file.

The health history should include past serious illnesses and injuries, current immunizations, weight, blood pressure and the results of any laboratory tests recommended by the examining physician. The physical assessment should be a systematic review of all sensory organs and their functioning, and the cardio-respiratory, gastrointestinal, musculo-skeletal and neurological systems. Any chronic or specific medical problem should be indicated and coupled with a statement noting the employee's ability to function in his/her position and/or any limitation which should be considered.

There should also be an emergency card for each employee including home address and phone number, the name of family member or friend and phone number where contact can be made, the family physician's name, address, telephone number and preferred hospital in the area. All employees should be under health supervision on a three-year cycle unless more frequent observation or contact is indicated.

The school nurse should plan for employees with policies and procedures for first aid and emergency care. Such a plan should include the employee's responsibilities for reporting and recording information regarding any accidents or injuries involving any pupil or staff member that occur on school property or on the way to and from school. Sample forms for collecting and storing this information are suggested on the following pages.

Sample Form

EMPLOYEE HEALTH HISTORY

NAME _____ AGE _____
Last First

ADDRESS _____ PHONE NUMBER _____

FAMILY PHYSICIAN _____ PHONE NUMBER _____

PERSON TO BE NOTIFIED IN CASE OF EMERGENCY _____
Last First

HEALTH HISTORY:

ACCIDENTS - (Serious) _____ DATE _____

ALLERGIES (Pollens, drugs) _____ ASTHMA _____

BLOOD TYPE _____ UNKNOWN _____

CONVULSIVE DISORDER _____ DIABETES _____

EARACHES _____ EYE PROBLEM _____ FAINTING SPELLS _____

FREQUENT COLDS _____ CRAMPS _____ HEADACHES _____

HEART CONDITION _____ HIGH BLOOD PRESSURE _____

HERNIA _____ KIDNEY DISEASE _____

INOCULATIONS: DATE OF SERIES OF TETANUS TOXOID AND/OR BOOSTER _____

OPERATIONS - (serious) _____ DATE _____

ORTHOPEDIC DEFECTS _____

RHEUMATIC FEVER _____

ARE YOU A POSITIVE TUBERCULIN REACTOR YES ( ) NO ( )

LIST ANY OTHER HEALTH PROBLEMS YOU MAY HAVE: _____

_____

_____

LIST ANY MEDICATIONS PRESENTLY PRESCRIBED: _____

_____

_____ _____
Signature of Applicant Date

Sample Form

PERSONNEL PHYSICAL EXAMINATION

NAME_____ POSITION_____

EXAMINATION:

BLOOD PRESSURE_____ IS THIS NORMAL FOR INDIVIDUAL?_____

HEART_____ IS THIS NORMAL FOR INDIVIDUAL?_____

LUNGS_____ IS THIS NORMAL FOR INDIVIDUAL?_____

EYES: RIGHT_____ LEFT_____ ABDOMEN_____

EARS (OTOSCOPIC)_____ HERNIA_____

LYMPH NODES_____ ORTHOPEDIC_____

THYROID_____ POSTURE_____

NOSE_____ FEET_____

MOUTH_____ SKIN (NONCOMM.)_____

NERVOUS DISORDER_____ REFLEXES_____

DEFORMITIES_____ ALLERGIES_____

HEIGHT_____ WEIGHT_____

GENERAL HEALTH: GOOD ( ) FAIR ( ) POOR ( )

TESTS:

URINALYSIS (if indicated)_____

HEMOGLOBIN (if indicated)_____

REMARKS AND RECOMMENDATIONS_____

_____

DATE_____

_____
Signature of Examining Physician

CHAPTER V

HEALTH TEACHING AND HEALTH COUNSELING

1. HEALTH TEACHING

Health teaching is the instruction of specific health concepts. It is the organization of learning experiences to develop or change health knowledge, attitudes and/or practices.

School nurses should incorporate health teaching in all school activities. Each screening program should be preceded with planned health instruction concerning that program. Information concerning why the program is being performed, what kind of results are considered normal/abnormal and what can be done to correct or remediate any abnormality should be provided to students. Prevention and safety factors as well as administration of first aid or emergency care should be included in a health teaching component.

If the pupil load permits and planned coverage for the health office is available, the school nurse, who is certified in health education, may be assigned to teach regular health classes. Formal health instruction by the school nurse should not exclude nor preclude school health services that are mandated by the state or established by district board policy. In most instances, the nurse will not be scheduled for classes but rather for specific units of the health education program.

The three areas of health education that nurses are most frequently involved in are: 1) nutrition, 2) dental health, and 3) family life education.

School nurses may plan special teaching units on any one or all of these topics and may be involved with other members of the school staff in curriculum development. In addition, school nurses may share in nutrition education in a number of ways. They may plan and conduct dietary surveys as part of a research program; assist in developing programs for better breakfast, weight control and nutritious snacking; conduct workshops for school faculty; assist in training programs for food service personnel; and help to interpret the educational and nutritional value of school meals. This latter activity encompasses dental health education as well as the nutrition. Other special dental health activities the nurse might consider are: planning special projects for Dental Health Education Week; conducting programs of flossing and/or brushing; participating in programs for parent education or parenting.

School nurses with a broad background in anatomy, physiology and psychology can participate in family life education; communicate to parents the importance of sequential sex education; assist in curriculum development; provide teachers with educationally and medically sound resource materials; present various aspect of the program; and/or be available to answer questions.

The findings of the health screenings and other physical/health examinations of pupils might be used to identify other areas of need in health education. The nurse must keep abreast of the latest medical and health facts so that she can integrate this knowledge into the curriculum. Bulletin boards can be used to display various health topics. These

displays can be prepared by the nurse or pupils in a health career club. Ideas for the displays can be elicited from pupils or other staff members.

2. HEALTH COUNSELING

Counseling is differentiated from health teaching in that it is a process occurring between two or more persons during a specific period of time designed to assist clients (pupils, parents, or staff) in improving their health status. School nurses can engage in health counseling on both a planned and an unplanned basis.

The particular counseling approach the nurse adopts is determined by a number of factors such as time constraints, the style of counseling with which she feels most comfortable, and the approach she deems most appropriate for the situation.

Planned health counseling may include, but not be limited to, health concerns such as adolescent growth and development, nutrition, peer pressures, smoking and drug dependencies, suspected pregnancy or other personal health problems. Unplanned health counseling occurs spontaneously between the school nurse and pupil during health appraisal activities and can be initiated by either the school nurse or the client.

The school nurse must consider the following when engaging in health counseling. She/he must be sure that:

1. It is realistic within time constraints of the school system.

2. There is a recognition and understanding of one's own values, beliefs and attitudes as well as those of the client.

3. Honesty, genuineness and professionalism are manifested at all times.

4. The client is encouraged to talk freely with assurance that confidentiality will be maintained.

5. The client is assisted in identifying the problem and the various ramifications.

6. The client is assisted in establishing realistic goals for resolution of the problem.

7. Approaches that may have already been tried by client are explored.

8. Alternatives are identified and client is assisted in weighing consequences of each plan of action.

9. The client is supported in the selection of a strategy he/she feels appropriate and able to follow.

10. The client is assisted in evaluating progress made toward the anticipated goal.

11. Reinforcement is given for any behavioral change.

12. The client is referred to other professionals within or outside of the school system when appropriate.

Communication, cooperative planning and coordination with other members of the pupil personnel staff such as school counselors, psychologists, social workers, speech correctionists and learning disabilities teacher-consultants will avoid confusion and overlapping of services. While health counseling is not a mandated service, it is an important aspect of the overall school health program.

CHAPTER VI

SUPERVISION OF THE ENVIRONMENT

The local board of education and administrators have a direct and continuing responsibility to provide pupils and staff with a safe and healthful school environment, which includes attention to the social and emotional factors related to healthful school living.

1. The Physical Environment

The physical environment includes attention to adequate ventilation, temperature control, lighting, seating, maintenance and safety of buildings and grounds and provision of barrier free or accessible facilities for handicapped pupils. In accordance with Section 504 of the Rehabilitation Act of 1973, Appendix B, this does not mean every facility must be accessible and barrier free but rather that the programs are somehow accessible to handicapped pupils.

Specific rules and regulations regarding facilities for the physically handicapped may be found in the N.J.A.C. 6:22-3.1. These regulations address such issues as ramps with gradients, the width of doors and doorways, stairs, floors, elevators, toilet and shower rooms, water fountains, telephones, warning signals and hazards. Suggested methods of compliance with program accessibility might include: delivering the programs or services at another site, assigning aides to the handicapped person, or architectural or equipment modification.

Chapter 1001 Sanitation of the Guide for Schoolhouse Planning indicates the following a minimum standards:

Toilets

Girls - grades 1-8	1:30 pupils
Boys - grades 1-8	1:60 pupils
Girls - grades 7-12	1:45 pupils
Boys - grades 7-12	1:90 pupils

Urinals

Boys - grades 1-8	1:30 pupils
Boys - grades 7-12	1:45 pupils

Lavatories

Boys and girls all grades	1:50 pupils

Inherent in these regulations is the fact that the above facilities are available and in working condition at all times.

As the school nurse visits the various areas of the school building, she/he should be aware of physical conditions and advise the classroom teacher or school administrator as indicated. Of course, conditions which may endanger the health or safety of pupils should receive priority for remediation.

2. Eye Protection

Each year many eye injuries occur in schools resulting in permanent vision loss and even total blindness. In order to prevent what is frequently unnecessary sight loss, the school nurse should be familiar with and consistently emphasize eye safety.

Periodic spot checks of chemical laboratories and shop areas should be made to insure that all safety measures and controls are being followed including the wearing of industrial quality safety eyewear (marked Z-87 on the frame). The nurse should be prepared to demonstrate the use of the eyewash kit or station to faculty and students.

The following are state law and State Board of Education rules and regulations concerning eye safety:

N.J.S.A. 18A:40-12.1. Protective eye devices required for teachers, pupils and visitors in certain cases.

The board of education of every school district shall require each pupil and teacher in the public schools of the district to wear industrial quality eye protective devices while attending classes in vocational or industrial art shops or laboratories in which caustic or explosive chemicals, hot liquids or solids, hot molten metals, or explosives are used or in which welding of any type, repair or servicing of vehicles, heat treatment or tempering of metals, or the milling, sawing, stamping or cutting of solid materials, or any similar dangerous process is taught, exposure to which might have a

tendency to cause damage to the eyes. Visitors to such classrooms or laboratories shall also be required to wear such protective devices.

N.J.S.A. 18A:40-12.2. Rules prescribing kinds, types and quality of devices.

The commissioner, by rule or regulation, shall prescribe the kinds, types and quality of such protective devices and in so doing, the commissioner shall be guided by the standards promulgated by the American Standards Association, Inc. for such protective devices.

[NOTE: A.S.A.I. is now known as the American National Standards Institute, Inc. (ANSI).]

N.J.A.C. 6:3-1.14. Eye protection in public schools.

(a) Each district board of education shall require each pupil, teacher and visitor in the public schools of the district, including evening adult school programs, to wear appropriate eye protective devices while participating in vocational education, industrial arts education, science education and arts education in which caustic or explosive chemicals or materials, hot liquids or solids, molten materials, welding operations of any type, repairing or servicing of vehicles, heat treatment or tempering of metals, the shaping of solid materials and laser device operation and experimentation or any similar process or activity is engaged in, exposure to which might have a tendency to cause damage to the eyes.

(b) The term 'appropriate eye protective device' shall include plano or prescription lenses provided the lenses and other portions of the device meet or exceed the prescribed specifications for the device. Specifications for appropriate eye protection for various activities shall meet or exceed standards described in paragraphs 1 and 2 below. The standards, with all subsequent amendments and supplements are hereby adopted as rules.

1. American National Standard Practice for Occupational and Educational Eye and Face Protection, ANSI Z78.1-1979.

2. American National Standard Practice for the State Use of Lasers, ANSI Z136.1-1980 and eye protective procedures recommended by the manufacturer of the laser device.

    i. These documents are available for review at the Administrative Code Office, Department of Education, 225 West State Street, CN 500, Trenton, New Jersey 08625.

    ii. These documents may be purchased from the American National Standards Institute, Incorporated 1430 Broadway, New York, New York 10018.

(c) Emergency eye wash fountains or similar devices, capable of a minimum 15 minutes continuous flow of eye wash solution shall be provided in classrooms, shops, laboratories or other areas where pupils or instructors are exposed to caustic materials that can cause damage to the eyes.

(d) The following types of eye protective devices shall be used to fit the designated activities or processes:

Potential Eye Hazard	Eye Protective Device(s)
1. Caustic or explosive materials	Goggle, flexible fitting, hooded ventilation; add plastic window face shield for severe exposure;
2. Dust producing operations	Goggle, flexible fitting, hooded ventilation
3. Electric arc welding	Welding helmet in combination with spectacles with eye cup or semi or flat-fold side shields;
4. Oxy-acteylene welding	Welding goggle, eye cup type with tinted lenses; welding goggle, coverspec type with tinted lenses or tinted plate lenses;
5. Hot liquids and gases	Goggle, flexible fitting, hooded ventilation; add plastic window face shield for severe exposure;
6. Hot solids	Clear or tinted goggles or spectacles with side shields;
7. Molten materials	Clear or tinted goggles and plastic or mesh window face shields;
8. Heat treatment or tempering	Clear or tinted goggles or clear or tinted spectacles with side shields;
9. Glare operations	Tinted goggles; tinted spectacles with side shields or welding goggles, eye cup or coverspec type with tinted lenses or plate lenses;
10. Shaping solid materials	Clear goggles, flexible or rigid body; clear spectacles with side shields; add plastic window face shield for severe exposure;

11. Laser device operation of experimentation	Appropriate for specific hazard;
12. Repair or servicing of vehicles	Clear goggles, flexible or rigid body; clear spectacles with side shields;
13. Other potentially eye hazardous processes or activities.	Appropriate for specific hazard.

(e) Each district board of education shall establish and implement specific eye protective policy and program to assure that:

1. No teacher, pupil or visitor shall be subjected to any hazardous environmental condition without appropriate eye protection.

2. The detection of eye hazardous conditions shall be continuous.

3. Eye protective devices shall be inspected regularly and adequately maintained.

4. Shared eye protective devices shall be disinfected between uses by a method prescribed by the local school medical inspector.

5. All eye protective devices shall meet or exceed the appropriate specifications for the various types of devices and suppliers of eye protective devices shall certify, in writing, that the device meets or exceeds said specifications.

6. Specific policies and procedures shall be established to deal with individuals who refuse to abide by established eye safety practices and procedures.

7. Contact lenses use shall be restricted in learning environments which entail exposure to chemical fumes, vapors or splashes, intense heat, molten metals, or highly particulate atmospheres. Contact lenses, when permitted, shall only be worn in conjunction with appropriate eye protective devices and the lens wearer shall be identified for appropriate emergency care in eye hazardous learning environments.

8. All spectacle type eye protective devices shall have side shields of the eye cup, semi or flat-fold type.

9. Pupils, teachers, or visitors wearing personal corrective eyewear shall be required to wear cover goggles or similar devices unless it can be certified, by competent authority, that the personal eyewear meets or exceeds standards identified in subsection (b) above.

N.J.A.C. 6:53-9.4 Emergency eyewash facilities

(a) Emergency eyewash equipment shall be installed in areas in which acid base battery electrolytes are used.

(b) Emergency eyewash stations may be of the protable or permanently installed type. The device shall be capable of providing a continuous flow of eyewash liquid for at least 15 minutes. Eyewash stations shall be inspected and maintained in accordance with the recommendations of the manufacturer.

3. THE EMOTIONAL CLIMATE

The mental/emotional climate of the school is a less tangible, but very important, aspect of the school health environment. It encompasses the interaction of pupils with one another, pupils with teachers, teachers with teachers and teachers with administrators. All pupil personnel services staff share the responsibility to promote positive mental/emotional health within the framework of the school. Because each person needs acceptance, recognition and security to achieve his/her goals, a healthy emotional climate fostering those elements must be nurtured and maintained.

Planning and organization of the school day are also important aspects of the emotional climate. Scheduling should include time for pupils to take care of their basic physical needs, and a change of activity with physical exercise to help improve pupil learning. Proper emphasis on healthful living habits in the school can influence the pupil in later life.

To a large degree, the healthful school environment is influenced by the attitudes and values of the total school population - pupils and staff. Developing and maintaining such an environment is a joint responsibility and can only be achieved through cooperative planning and organizational efforts.

4. HEALTH SERVICES OFFICE

The office(s) for providing school health services should be large enough for comfort and privacy, include a waiting room for pupils/staff, and provide enough space for the nurse to perform health screenings, administer first aid or emergency care, provide for physical examinations and house pupil health records. The Schoolhouse Planning Guide suggests an area 720 square feet to 1,000 square feet for the health office.

The health office should be located in an area convenient for pupils and staff and adjacent to areas where most pupil accidents occur. The room(s) should be attractively furnished and decorated with adequate heat, ventilation and lighting. Telephone, toilet facilities and ample water supply are required as well. Since the health office is also used for health counseling and informal teaching, well-planned, attractive bulletin boards should emphasize a health education topic or concept. The following lists suggest supplies and equipment for this facility.

Supplies

Assorted bandaids, gauze bandage, sterile gauze pads, adhesive tape and ace bandages
Cotton balls
Applicators, tongue depressors
Splints - finger tip, wooden or inflatable (various sizes)
Ice packs (reusable and instant)
Eye pads
Triangular bandage
Aromatic spirits of ammonia
Tissues
Safety pins (assorted)
Plastic trash can liners
Paper bags, baggies
Salt, sugar, baking soda
Paper or professional towels
Alcohol, acetone
Materials for testing for tuberculosis infection
Miscellaneous - antiseptics, etc.

Equipment

Desk, chair, telephone (intercom and outside lines)
Waste cans - (step-on-can and regular)
Couch(es) with table paper roll(s), blanket(s)
Small refrigerator
Files - four drawer and other appropriate files (locked)
Storage space for supplies
Medicine cabinet (locked)
Paper cups and dispensers
Wash basin, emesis basin
Stethoscope, sphygmomanometer with adult and child size cuffs
Gooseneck lamp, flashlight, penlight
Otoscope
Stretcher chair, wheel chair
Scale
Audiometer
Vision testing equipment
Lighted magnifying glass
Resuscitube
Oxygen (portable)
Splinter forceps, cuticle scissors
Bandage scissors
Thermometers and holders
Reference materials - Medical Dictionary
Physician's Desk Reference
Merck Manual
Directories - phone, county nurses
Manual - local policies, procedures, protocols

APPENDIX A

NEW JERSEY STATUTES REGARDING SCHOOL HEALTH

N.J.S.A. 18A:16-2. Physical examinations; requirement

Every board of education shall require all of its employees, and may require any candidate for employment, to undergo a physical examination, the scope whereof shall be determined under rules of the state board, at least once in every year and may require additional individual psychiatric or physical examinations of any employee, whenever, in the judgment of the board, an employee shows evidence of deviation from normal, physical or mental health.

Any such examination may, if the board so requires, include laboratory tests of fluoroscopic or X-ray procedures for the obtaining of additional diagnostic data.

N.J.S.A. 18A:16-3. Character of examinations

Any such examination may be made by a physician or institution designated by the board, in which case the cost thereof and of all laboratory tests and fluoroscopic or X-ray procedures shall be borne by the board or, at the option of the employee, they may be made by a physician or institution of his own choosing, approved by the board, in which case said examination shall be made at the employee's expense.

N.J.S.A. 18A:16-4. Sick leave; dismissal

If the result of any such examination indicates mental abnormality or communicable disease, the employee shall be ineligible for further service until proof of recovery, satisfactory to the board, is furnished, but if the employee is under contract or has tenure, he may be granted sick leave with compensation as provided by law and shall, upon satisfactory recovery, be permitted to complete the term of this contract, if he is under contract, or be reemployed with the same tenure as he possessed at the time his services were discontinued, if he has tenure, unless his absence shall exceed a period of two years.

N.J.S.A. 18A:16-5. Records of examinations

All records and reports relating to any such examination shall be the property of the board and shall be filed with its medical inspector as confidential information but shall be open for inspection by officers of the State Department of Health and the local board of health.

N.J.S.A. 18A:28-4. Teaching staff members not certified, not to obtain tenure; exception

No teaching staff member shall acquire tenure in any position in the public schools in any school district or under any board of education, who is not the holder of an appropriate certificate for such position, issued by the State Board of Examiners, in full force and effect, except that no board of

education shall terminate the employment or refuse to continue the employment or re-employment of any school nurse appointed prior to May 9, 1947 for the reason that such nurse is not the holder of such a certificate and the state board of examiners shall make no rule or regulation which will affect adversely the rights of any such nurse under any certificate issued prior to said date.

N.J.S.A. 18A:28-5. Tenure of teaching staff members

The services of teaching staff members including all teachers, principals, assistant principals, vice principals, superintendents, assistant superintendents, and all school nurses including school nurse supervisors, head school nurses, chief school nurses, school nurse coordinators, and any other nurse performing school nursing services and such other employees as are in positions which require them to hold appropriate certificates issued by the board of examiners, serving in any school district or under any board of education, excepting those who are not the holders of proper certificates in full force and effect, shall be under tenure during good behavior and efficiency and they shall not be dismissed or reduced in compensation except for inefficiency, incapacity, or conduct unbecoming such a teaching staff member or other just cause and then only in the manner prescribed by subarticle B of article 2 of chapter 6 of the title, after employment in such district or by such board for:

(a) three consecutive calendar years, or any shorter period which may be fixed by the employing board for such purpose; or

(b) three consecutive academic years, together with employment at the beginning of the next succeeding academic year; or

(c) the equivalent of more than three academic years within a period of any four consecutive academic years;

provided that the time in which such teaching staff member has been employed as such in the district in which he was employed at the end of the academic year immediately preceding July 1, 1962, shall be counted in determining such period or periods of employment in that district or under that board but no such teaching staff member shall obtain tenure prior to July 1, 1964 in any position in any district or under any board of education other than as a teacher, principal, assistant superintendent or superintendent, or as a school nurse, school nurse supervisor, head school nurse, chief school nurse, school nurse coordinator, or as the holder of any position under which nursing services are performed in the public schools.

N.J.S.A. 18A:28-14. Teaching staff members not certified; not protected; exception

The services of any teaching staff member who is not the holder of an appropriate certificate, in full force and effect, issued by the State Board of Examiners under rules and regulations prescribed by the State Board of Education may be terminated without charge or trial, except that any school nurse appointed prior to May 9, 1947 shall be protected in her position as is provided in section 18A:28-4 of this title.

N.J.S.A. 18A:29-4.2. Payment of school nurse according to teachers' salary guide

Any teaching staff member employed as a school nurse and holding a standard school nurse certificate shall be paid according to the provisions of the teachers' salary guide in effect in that school district including the full use of the same experience steps and training levels that apply to teachers.

N.J.S.A. 18A:40-1. Employment of medical inspectors, optometrists and nurses; salaries; terms; rules

Every board of education shall employ one or more physicians, licensed to practice medicine and surgery within the state, to be known as the medical inspector or medical inspectors, and any board, not furnishing nursing services under a contract pursuant to section 18A:40-3.1 shall employ one or more school nurses, and it may also employ one or more optometrists, licensed to practice optometry within the state, to be known as the school vision examiner or school vision examiners, and the board shall fix their salaries and terms of office.

Every board of education shall adopt rules, subject to the approval of the state board, for the government of such employees.

N.J.S.A. 18A:40-3. Lectures to teachers

A medical inspector or nurse shall lecture to the teachers at such times as may be designated by the board of education instructing them concerning the

methods employed to detect the first signs of communicable disease and the recognized measures for promotion of health and the prevention of disease.

N.J.S.A. 18A:40-3.1. Appointment and salary, school nurses, etc.

Every person employed as a school nurse, school nurse supervisor, head school nurse, chief school nurse or school nurse coordinator, or performing any school nursing service, in the public schools of this state shall be appointed by the board of education having charge of the school or schools in which the services are to be rendered and shall be under the direction of said board or an officer or employee of the board designated by it and the salary of such person shall be fixed by, and paid from the funds of said board according to law, except that the performance for school nursing services in any public school in this state may be continued, under any original contract or agreement entered into, prior to February 27, 1957, or under any renewal or modification thereof, during the term of such contract or agreement or renewal or modification thereof.

N.J.S.A. 18A:40-4. Examination for physical defects and screening of hearing of pupils; health records

The medical inspector, or the nurse or licensed medical and health care personnel under the immediate direction of the medical inspector, shall examine every pupil to learn whether any physical defect exists, or in lieu thereof the medical inspector may accept the report of such an examination by a physician licensed to practice medicine and surgery within the State

and the frequency and procedure of and selection of pupils for such examinations shall comply with the rules of the State Board. Additionally a screening of hearing examination shall be conducted on each pupil during the school year pursuant to rules, regulations and standards established by the State Department of Education in consultation with the State Department of Health. A pupil who presents a statement signed by his parent or guardian that such required examinations interfere with the free exercise of his religious beliefs shall be examined only to the extent necessary to determine whether he is ill or infected with a communicable disease or to determine his fitness to participate in any health, safety and physical education course required by law. A health record of each pupil shall be kept, in which shall be entered the findings of each examination, and such record shall be the property of the board of education and shall be forwarded to any public school to which the pupil is transferred, if such school is known.

N.J.S.A. 18A:35-4.6 Title of act

This act shall be known as the "Parents Rights to Conscience Act of 1979."

N.J.S.A. 18A:35-4.7. Parent's statement of conflict with conscience

Any child whose parent or guardian presents to the school principal a signed statement that any part of the instructions in health, family life education or sex education is in conflict with his conscience, or sincerely held moral or religious beliefs shall be excused from that portion of the course where such instructions is being given and no penalties as to credit or graduation shall result therefrom.

N.J.S.A. 18A:35-4.8. Medical treatment or examination; objection of parent or guardian

No pupil whose parent or guardian objects to such pupil receiving medical treatment or medical examination or physical examination shall be compelled to receive such treatment or examination; provided however, that no objection shall be made to a physical or medical examination of any physically handicapped child for the purpose of determining whether such child shall be admitted to any class or school for handicapped children or of any pupil to determine whether he is ill or infected with a communicable disease or of any person who appears to be under the influence of a drug pursuant to P.L. 1971, c. 390 (C. 18A:40-4.1).

N.J.S.A. 18A:40-4.3. Scoliosis; annual examination; notice to parents or guardian

Every board of education shall provide for the yearly examination of every pupil between the ages of 10 and 18 for the condition known as scoliosis in accordance with standards jointly established and promulgated by the Departments of Health and Education. Such examination shall be carried out by a school physician, school nurse, physical education instructor or other school personnel properly trained in the screening process for scoliosis. Every board of education shall further provide for the notification of the parents or guardian of any pupil suspected of having scoliosis. Such notification shall include an explanation of scoliosis, the significance of treating it at an early stage, and the public services available, after diagnosis, for such treatment.

N.J.S.A. 18A:40-4.4. Exemption

Any pupil shall be exempt from the examination upon written request of his parent or guardian.

N.J.S.A. 18A:40-4.5. Immunity from action of any kind due to provisions of act

No action of any kind in any court of competent jurisdiction shall lie against any physician, school nurse, physical education instructor or other school personnel by virtue of the provisions of this act.

N.J.S.A. 18A:40-5. Method of examination; notice to parent or guardian

In conducting such examinations of pupils the medical inspector may require pupils to loosen, open, or remove their clothing above the waist in a manner to facilitate inspection and examination, but in any such case the parents or guardians shall be notified in writing of such proposed examination and in such notice the presence of one of the parents or guardians shall be requested, and it shall be stated in the notice that in the absence of a parent of guardian there shall be present a nurse or teacher and in the examination of a female pupil the nurse or teacher present shall be of the female sex, and that if the parent or guardian objects to such examination, then the parent or guardian may file with the medical inspector a report of the family physician upon the condition for which such examination was deemed advisable by the medical inspector.

N.J.S.A. 18A:40-6. In general

The board of education of any district may provide such equipment, supplies, and services as in its judgment will aid in the preservation and promotion of the health of the pupils, subject to the provisions of section 18A:18-5.1.

N.J.S.A. 18A:40-7. Exclusion of pupils who are ill

When there is evidence of departure from normal health of any pupil, the principal of the school shall upon the recommendation of the school physician or school nurse exclude such pupil from the school building, and in the absence from the building of the school physician or school nurse, the classroom teacher may exclude the pupil from the classroom and the principal may exclude the pupil from the school building.

N.J.S.A. 18A:40-8. Exclusion of pupils whose presence is detrimental to health and cleanliness

The principal may, upon the recommendation of the school physician or the school nurse, if either of them are present in the building, exclude from school any pupil who has been exposed to a communicable disease or whose presence in the school room is certified by the medical inspector as detrimental to the health or cleanliness of the pupils in the school, and in the absence from the building of the school physician or school nurse, the classroom teacher may exclude the pupil from the classroom and the principal may exclude the pupil from the school building and the principal or the classroom teacher, as the case may be, shall notify the parent, guardian or other person having control of the pupil of the reason for his exclusion.

N.J.S.A. 18A:40-9. Failure of parent to remove cause for exclusion; penalty

If the cause for exclusion under this article is such that it can be remedied, and the parent, guardian or other person having control of the pupil excluded shall fail within a reasonable time to have the cause for the exclusion removed, the parent, guardian or other person shall be proceeded against, and upon conviction, be punishable as a disorderly person.

N.J.S.A. 18A:40-10. Exclusion of teachers and pupils exposed to disease

No teacher or pupil who is a member of a household in which a person is ill with small-pox, diphtheria, scarlet fever, whooping cough, yellow fever, typhus fever, cholera, measles, or such other contagious or infectious disease as may be designated by the board of education, or of a household exposed to contagion as aforesaid, shall attend any public school during such illness, nor until the board of education has been furnished with a certificate from the board of health, or from the physician attending such person, or from a medical inspector, certifying that all danger of communicating the disease by the teacher or pupil has passed.

N.J.S.A. 18A:40-11. Exclusion of pupils having tuberculosis

Any pupil found to have communicable tuberculosis shall be excluded from school and a report of each such case shall be filed by the school medical inspector with the health officer of the municipality in which the pupil

resides. Readmission to school may be granted when proof satisfactory to the school medical inspector is furnished to indicate that the pupil is free from communicable tuberculosis.

N.J.S.A. 18A:40-12. Closing schools during epidemic

Whenever the board of health of any municipality shall declare any epidemic or cause of ill health to be so injurious or hazardous as to make it necessary to close any or all of the public schools in the municipality, the board shall immediately serve notice on the board of education of the school district situated in the municipality that it is desirable to close the school or schools. Upon receipt of the notice the board of education may close the schools under its control, or such of them as may be designated by the board of health. The schools so closed shall not be reopened until the board of education is satisfied that all danger from the epidemic or cause of ill health has been removed.

N.J.S.A. 18A:40-12.1 Protective eye devices required for teachers, pupils and visitors in certain cases

The board of education of every school district shall require each pupil and teacher in the public schools of the district to wear industrial quality eye protective devices while attending classes in vocational or industrial art shops or laboratories in which caustic or explosive chemicals, hot liquids or solids, hot molten metals, or explosives are used or in which welding of any type, repair or servicing of vehicles, heat treatment or tempering of

metals, or the milling, sawing, stamping or cutting of solid materials, or any similar dangerous process is taught, exposure to which might have a tendency to cause damage to the eye. Visitors to such classrooms or laboratories shall also be required to wear such protective devices.

N.J.S.A. 18A:40-12.2 Rules prescribing kinds, types and quality of devices

The commissioner, by rule or regulation, shall prescribe the kinds, types and quality of such protective devices and in so doing; the commissioner shall be guided by the standards promulgated by the American Standards Association, Inc. for such protective devices.

N.J.S.A. 18A:40-16. Tuberculosis; determining presence of

The board of education of every school district shall periodically determine or cause to be determined the presence or absence of infection tuberculosis in any or all pupils in public schools, and, with respect to frequency, procedure, and selection of pupils, shall comply with the rules of the State Board.

N.J.S.A. 18A:40-17. Equipment, materials and services for tuberculosis tests

The board may provide at its expense the equipment, materials, and services necessary to make such determination, or it may contract to use for that

purpose, with or without financial reimbursement, the equipment, materials, and services available through a hospital or a public health agency approved by the State Department of Health.

N.J.S.A. 18A:40-18. Exclusion of pupils failing to comply with rules and orders

Any pupil failing to comply with the rules of the board of education relating to the determination of the presence of tuberculosis or any order issued by a school officer pursuant to such rules may be excluded from school.

N.J.S.A. 18A:40-19. Records and reports of tuberculosis testing; disposition; inspection

All records and reports of tuberculosis testing procedures conducted by or under the auspices of a board of education shall be the property of the board and shall be filed with the medical inspector as confidential information except that such records and reports shall be open for inspection by officers of the State Department of Health and of the local board of health, of the municipality in which the pupil resides and of the municipality in which the school is located.

N.J.S.A. 18A:40-20. Vaccination at public expense

A board of education may provide, at public expense, the necessary equipment, materials and services for immunizing pupils from the disease

which pupils are required to be immunized against by the State Sanitary Code or for diseases against which immunization may be recommended by the State Department of Health.

N.J.S.A. 18A:43-1. Accident insurance for pupils authorized

The board of education in any school district may arrange for and maintain, and may pay the premiums for policies of accident insurance with any insurance company created by or under the laws of this state or authorized by law to transact business in this state, to provide for payments to pupils of the school district in connection with loss resulting from bodily injury sustained by such pupils through accidental means while participating in, practicing or training for, or during transportation to or from games or contests conducted by the school district, or by any school of the district, or with the consent of the board of education or of the school and under the supervision of an employee of the board of education, and for payments to pupils injured in connection either with the conduct of the regular curricular, and extra-curricular programs of the district or with student travel to and from the places where such programs of the district and which travel to and from the places where such programs are conducted and which travel is made necessary by such programs.

N.J.S.A. 18A:43-2. Payment by pupils of proportionate share of premiums

A board of education maintaining such accident insurance for the benefit of its pupils may require the payment to the board of education by pupils, to

whom the benefit of such insurance is extended, of a proportionate share of the premiums or any part thereof. The sums to be paid by the pupils shall be established by a schedule determined by the board of education, but no pupil electing not to participate in the accident insurance coverage, shall be required to make any payment toward the cost of the premiums therefor.

N.J.S.A. 18A:43-3. No liability imposed on board of education

The provisions of this chapter shall not be construed to impose any liability on the part of a board of education for injury sustained by a pupil as a result of or in connection with any of the games or contests hereinabove mentioned, or as a result of or in connection with the conduct of the physical education program of the school district or of any school of the district.

APPENDIX B

NEW JERSEY STATUTES REGARDING ALCOHOL AND DRUGS

N.J.S.A. 18A:4-28.7. Drug education unit incorporated into curriculum.

On and after January 15, 1971, each school district having secondary school grades shall incorporate into its health education curriculum the recommended drug education unit provided for in section 2 hereof during a minimum of 10 clock hours per school year as part of the ongoing health education curriculum for secondary school grades.

N.J.S.A. 18A:35-4. Course in nature and effect of alcoholic drinks and narcotics.

The nature of alcoholic drinks and narcotics and their effects upon the human system shall be taught in all schools supported wholly or in part by public moneys in such manner as may be adapted to the age and understanding of the pupils and shall be emphasized in appropriate places of the curriculum sufficiently for a full and adequate treatment of the subject. The commissioner shall, with the approval of the State Board, in cooperation with the Education Improvement Centers and in consultation with the Department of Health, prepare and update as necessary curriculum guidelines to assist boards of education in fulfilling this requirement. Each board of education shall make provisions in its annual educational program to fulfill this requirement and with respect to their effects upon the human system, each board shall consult with a local organization involved with the prevention, detection, and treatment of alcoholism approved by the Department of Health.

N.J.S.A. 18A:35-4a. Evaluation and treatment of pupils involved with possession or consumption of alcoholic beverages.

Each board of education shall adopt and implement, in accordance with rules and regulations promulgated by the State Board, policies and procedures for the evaluation and treatment of pupils involved in incidents of possession or consumption of alcoholic beverages on school property or at school functions, or who show significant symptoms of intoxication or of alcoholism on school property or at school functions. In adopting and implementing these policies and procedures, the board shall consult and work closely with a local organization involved with the prevention, detection and treatment of alcoholism approved by the Department of Health.

N.J.S.A. 18A:40-4.1. Pupil under influence of narcotics drug, report, examination, suspension.

Whenever it shall appear to any teaching staff member, school nurse or other educational personnel of any public school in this state that a pupil may be under the influence of a controlled dangerous substance as defined in P.L. 1970, chapter 226, section 2 (C. 24:21-2) or any chemical or chemical compound which releases vapor or fumes causing a condition of intoxication, inebriation, excitement, stupefaction, or dulling of the brain or nervous system including but not limited to glue containing a solvent having the property of releasing toxic vapors or fumes, as defined in P.L. 1965, chapter 41, section 1, (C. 2A:1970-25.9) taken for purposes other than the treatment of sickness or injury as prescribed or administered by a person duly authorized by law to treat the sick and injured human beings, such teaching staff member, school nurse or other educational personnel shall

report the matter as soon as possible to the school nurse or medical inspector, as the case may be and to the principal or, in his absence, to his designee. The principal or his designee shall immediately notify the parent or guardian and the superintendent of schools, if there be one, or the administrative principal and arrange for an immediate examination of the pupil by a doctor selected by the parent or guardian, or if such doctor is not immediately available, by the medical inspector if he is available. If the medical inspector is not immediately available, the pupil shall be taken to the emergency room of the nearest hospital for examination accompanied by a member of the school staff designated by the principal and a parent or guardian of the pupil if available. The pupil shall be examined as soon as possible for the purpose of diagnosing whether or not the pupil is under such influence. A written report of said examination shall be furnished within 24 hours by the examining physician to the parent or guardian of the pupil and to the superintendent of schools or administrative principal. If such diagnosis is positive, the pupil shall be returned to his home as soon as possible and the appropriate data shall be furnished to the Department of Health pursuant to the "Controlled Dangerous Substances Registry Act of 1970," P.L. 1970, chapter 227 (C. 26:2G-17, et seq.). The pupil shall not resume attendance at school until he submits to the principal a written report certifying that he is physically and mentally able to return thereto, which report shall be prepared by his personal physician, the medical inspector or the physician who examined him pursuant to the provisions of this act.

N.J.S.A. 18A:40-2. No legal action against teacher.

No action of any kind in any court of competent jurisdiction shall lie against any teaching staff member, school nurse or other educational personnel, medical inspector, examining physician or any other officer or agent of the board of education or personnel of the emergency room of a hospital because of any action taken by virtue of the provisions of this act, provided the skill and care given is that ordinarily required and exercised by other such teaching staff members, nurses, educational personnel, medical inspectors, physicians or other officers or agents of the board of education or emergency room personnel.

N.J.S.A. 2A:62A-4. Reports by educational personnel on dependency upon or illegal use of controlled dangerous substances or use of intoxicating vapor releasing chemical; immunity from liability.

Any teacher, guidance counselor, psychologist, registered nurse or other educational personnel employed by or in any of the public or private schools of this State who in good faith reports a person to the principal or his designee or to the medical inspector or school physician or school nurse in an attempt to help such person cure his dependency upon illegal use of controlled dangerous substances as defined in P.L. 1970, chapter 226, section 2 (C:24-2I-1), or such chemical or chemical compound as defined in P.L. 1965, chapter 41, section 1 (C. 2A:170-25.9), shall not be liable in civil damages as a result of making any such report.

APPENDIX C

NEW JERSEY ADMINISTRATIVE CODE REGARDING SCHOOL HEALTH, SAFETY AND PHYSICAL EDUCATION

CHAPTER 29
HEALTH, SAFETY AND PHYSICAL EDUCATION

FOREWORD

The Office of Health, Safety and Physical Education assists local schools in the development and implementation of programs designed to promote the health, safety and well-being of school age children in this State.

The functions of the Office of Health, Safety and Physical Education being met by the staff members include: school health services; school health instruction; school safety instruction; driver education; physical education and athletics.

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SUBCHAPTER 1. SCHOOL HEALTH RULES

6:29-1.1 Rules and regulations

(a) Every board of education in this State shall adopt rules to govern health services in its school district and such rules and regulations shall include as a minimum the rules and regulations of the State Board of Education which are expressed in the following sections.

(b) Every board of education in this State shall appoint at least one medical inspector.

(c) Boards of education, medical inspectors, any medical specialists employed by a school board, school dentists, teachers of health, and nurses shall at all times comply with the rules and regulations of the local boards of health and of the State Department of Health which relate to the sanitation of public grounds and buildings and to the prevention and control of communicable diseases.

(d) Medical inspectors shall omit dental examinations in making physical examinations of pupils who have been or will be examined by a school dentist in the current school year.

(e) For beginning pupils, medical inspectors may accept a record of a thorough physical examination made by a family physician or by a physician working under a plan for the examination of preschool children; provided, that the plan for the records or reports used in either type of examination have been approved by the State Board of Education.

(f) If a board of education requires the medical inspector to undertake special work not included in these rules or required by statute, the board shall enter into an agreement with the medical inspector concerning such additional duties.

(g) Reparative dentistry shall be limited to pupils whose parents indicate consent to such treatment upon a form provided for the purpose by the board of education and filed with the school principal, but in no case shall a pupil be required to undergo treatment against his will.

(h) Boards of education shall submit reports of the dental health service to the Commissioner of Education from time to time and in the form recommended by the Commissioner of Education.

Case Note

Presence of properly certified school nurse in building.
See, *Smith v. Bd., of Ed., Caldwell-W. Caldwell*, 1972 *S.L.D.* 232.

6:29–1.2 Facilities and supplies

(a) Boards of education shall furnish each school building within their jurisdictions with an emergency kit or cabinet with first aid equipment and supplies prescribed by the medical inspector.

(b) Boards of education shall provide proper and adequate facilities for the medical inspector, dentist, and nurse, and the equipment and supplies necessary for the proper performance of their duties.

(c) Boards of education shall provide by regular appropriations suitable and adequate equipment for carrying out the program for physical education activities.

(d) Boards of education shall provide the necessary text and reference books, informational materials and teaching devices necessary for carrying out the instruction required by the statute in physical education, safety, alcohol, tobacco and narcotics.

(e) Adequate school facilities shall include:

1. Good drinking water within the school building or upon the school grounds. If within the school building, the water shall be available from faucet, drinking fountain, or closed container. No drinking water may be kept in open containers. Individual drinking cups shall be required, except where drinking fountains are in use. Boards of education shall have drinking water from local sources tested at least once during each school year. The Commissioner of Education is authorized to designate the month during which a board shall submit samples of water to the State Board of Health, according to the schedule provided by the State Board of Health.

2. Schools shall be furnished with adequate lavatory equipment. Such equipment shall be reasonable in amount and shall include lavatories or basins, an ample supply of water, liquid or powdered soap, and individual towels. The equipment shall be kept in sanitary condition.

3. All toilets shall be kept in sanitary condition and shall be supplied with toilet paper.

(f) The Commissioner of Education shall require all boards of education to comply with the provisions of this section.

SUBCHAPTER 2. SCHOOL HEALTH ORGANIZATION AND SUPERVISION

6:29–2.1 Cooperating agencies

(a) Any program or plan sponsored or conducted by a person, an organization, or a public or private agency for the purpose of providing dental or nursing services, safety programs, athletic programs, lunchroom facilities, or any other services which aid in the preservation and promotion of the health of school pupils, through coordination with or as a part of the school organization regardless of the location of the facilities and equipment used, shall be under the jurisdiction of the board of education. The board shall approve all programs, have administrative direction of the pupils, and of the personnel working with the pupils, and shall approve and have control of records and reports.

(b) Rules and practices adopted by boards of education to govern the supervision of pupil health, the hygienic management of classrooms by teachers, and the sanitary operation and maintenance of the school buildings, grounds, and equipment by custodians, matrons, and firemen shall be explained to the personnel annually by the principal, medical inspector or nurse.

6:29–2.2 Supervision

Rules and practices adopted by boards of education to govern the supervision of pupil health, the hygienic management of classrooms by teachers, and the sanitary operation and maintenance of the school buildings, grounds, and equipment by custodians, matrons, and firemen shall be explained to the personnel annually by the principal, medical inspector or nurse.

Case Note

Presence of properly certified school nurse in school building.
See, *Smith v. Bd. of Ed., Caldwell-W. Caldwell* 1972 *S.L.D.* 232.

6:29–2.3 Care of injured pupils

Boards of education shall adopt rules and a program of procedures for the care of pupils injured at school and shall require that such rules and

program be explained at the beginning of each school year to all employees and that copies be posted in each school at points conveniently accessible to the personnel.

Case Note

Presence of properly certified school nurse in school building.
See, *Smith v. Bd., of Ed., Caldwell-W. Caldwell,* 1972 *S.L.D.* 232.

SUBCHAPTER 3. SCHOOL HEALTH SERVICES PERSONNEL

6:29-3.1 School medical inspector

(a) The medical inspector shall direct the professional duties or activities of the school nurse and shall compile and issue regulations governing professional techniques, the conduct of inspections or tests and the administration of treatment.

(b) Each medical inspector shall record the results of examinations upon a record form recommended by the Commissioner of Education. Such form shall be kept in a permanent file and shall be the property of the board of education and shall be preserved. The individual health record shall be forwarded with other school records of pupils who transfer to another school district. If a child leaves school for any other reason, the record shall remain the property of the school.

Case note

Presence of properly certified school nurse in school building.

See, *Smith v. Bd., of Ed., Caldwell-W. Caldwell,* 1972 *S.L.D.* 232.

6:29-3.2 School nurse

All nurses engaged in any capacity in the public schools shall comply with the rules and regulations of the local board or boards of education having jurisdiction, and shall be subject to the administrative authority of such school and school districts.

6:29-3.3 Compliance with health regulations

Boards of education, medical inspectors, any medical specialist employed by a school board, school dentists, teachers of health and nurses shall at all times comply with the rules and regulations of the local boards of health and of the State Department of Health which relate to the sanitation of public grounds and buildings and to prevention and control of communicable diseases.

SUBCHAPTER 4. SCHOOL HEALTH SERVICES PROCEDURES

Authority

N.J.S.A. 18A:4-15, 18A:16-2, 18A:40-3, 18A:40-4 and 18A:40-16.

Source and Effective Date

R.1984 d.264, effective June 13, 1984.
See: 16 N.J.R. 300(a), 16 N.J.R. 1731(a).

Executive Order 66(1978) Expiration Date

Pursuant to the requirements and criteria of Executive Order 66(1978), this subchapter expires on July 1, 1989, as established by readoption, R.1984 d.264, effective June 13, 1984.
See: 16 N.J.R. 300(a), 16 N.J.R. 1731(a).

6:29-4.1 Dental examination

(a) The school dentist shall direct the professional duties or activities of the dental assistant or of the nurse assigned to the dental service.

(b) Reparative dentistry shall be limited to pupils whose parents indicate consent to such treatment. In no case shall a pupil be required to undergo treatment against his or her will.

(c) Each school dentist or any dentist examining or treating pupils with the approval of the district board of education shall record the results of examinations, treatment administered, and recommendations upon the health records of the pupils.

(d) The results of dental examinations or of treatment administered or recommended shall be reported to parents.

As amended, R. 1984 d.278, eff. July 2, 1984.
See: 16 N.J.R. 300(a), 16 N.J.R. 1731(a).
Section substantially amended.

6:29-4.2 Testing for tuberculosis infection

(a) The following are rules of the State Department of Education concerning testing for tuberculosis infection by district boards of education for implementation of N.J.S.A. 18A:16-2 and 40-16.

1. The Mantoux intradermal tuberculin test using five T.U. (Tuberculin Units) of PPD tuberculin shall be the only skin test used to detect evidence of tuberculosis infection in pupils and employees.

2. The only pupils who shall be tested are those in grades and schools identified and/or under circumstances specified by the State Department of Health based upon the high incidence of tuberculosis or reactor rates in the communities or population groups concerned.

3. In every school district a Mantoux intradermal tuberculin test shall be given to all employees (full-time and part-time), all student teach-

ers, and other persons who have contact with pupils. If the Mantoux intradermal tuberculin test shows less than 10 mm of induration, the above persons shall be retested with a Mantoux intradermal tuberculin test every three years.

4. Any pupil or employee shall be exempt from these requirements upon presentation of documentation of a prior significant reaction evidenced by vesiculation following the administration of a multiple puncture tuberculin test or a significant reaction (that is, 10 mm or more of induration) following a Mantoux intradermal tuberculin test with five tuberculin units of stabilized PPD tuberculin. Any other exemption from these requirements shall be because of medical contraindictions subject to review by the medical inspector.

5. All tuberculin reactors as defined in (a)4 above shall be referred to the family physician and appropriate official health agency for necessary follow-up. The following shall constitute standards for referral:

i. If there is documentation showing that vesiculation resulted from a previous multiple puncture test, the individual shall be recorded as a positive tuberculin reactor, and no further tuberculin testing is required;

ii. If the reaction to the Mantoux intradermal tuberculin test is doubtful (five to nine mm of induration), it shall be repeated at a different site on the forearm. If the result of the second Mantoux intradermal tuberculin test is also five to nine mm of induration, the individual shall be recorded as tuberculin negative. If the result of the Mantoux test shows 10 or more mm of induration, the individual shall be recorded as a tuberculin reactor, and no further tuberculin testing is required.

6. A chest X-ray shall be administered to all pupils, employees and other personnel who have a significant reaction to a Mantoux intradermal tuberculin test as defined in (a)4 above.

7. All pupils, employees and other personnel required to have a chest X-ray shall be referred to their family physician or other medical facility for the necessary medical evaluation, including a chest X-ray. If the physician's report is not received by the school physician within four weeks, or if the school physician is unwilling to accept the findings, the pupil, employee or other persons who have contact with pupils shall have a chest X-ray examination in the manner prescribed by the district board of education.

8. If the chest X-ray of a tuberculin reactor is negative for evidence of tuberculosis, chemoprophylaxis or preventive therapy, with one year of isoniazid (INH) is strongly recommended.

9. A tuberculin reactor who is certified in writing by a licensed physician to have completed one year of preventive treatment (chemopro-

phylaxis) with isoniazid (INH) shall not be required to undergo any further testing for tuberculosis.

10. Employees and pupils who have a significant reaction to the Mantoux intradermal tuberculin test and an initial chest X-ray that was negative, or who present a medical certificate showing a significant tuberculin reaction and a subsequent negative chest X-ray, shall require no further testing for tuberculosis infection.

11. The reporting of the testing for evidence of tuberculosis infection by each district board of education shall be as follows:

i. The name and address, grade (of pupils), age and school of all newly discovered tuberculin reactors, chest X-ray results and prescription of preventive therapy are to be reported immediately upon discovery to the New Jersey State Department of Health, and to the local health department or local tuberculosis control center, on a special form provided for this purpose so that the appropriate tuberculosis control measures can be instituted;

ii. At the end of the annual tuberculosis testing program for staff and in grades and schools as specified by the New Jersey State Department of Health, the following information shall be reported to the New Jersey State Department of Health, and the local health department or tuberculosis control center, with one copy to be retained by the district board of education:

(1) The number of Mantoux tuberculin tests performed by grade and school, on pupils, employees and other persons who have contact with pupils;

(2) X-ray findings;

(3) Number of pupils and employees for whom isoniazid prophylaxis was prescribed;

(4) The name, address, date of birth, school and grade of each case of tuberculosis found as a result of the Mantoux intradermal tuberculin testing program.

As amended, R.1974 d.154, eff. June 19, 1974.
See: 6 N.J.R. 258(c).
As amended, R.1974 d.155, eff. June 19, 1974.
See: 6 N.J.R. 258(c).
As amended, R.1977 d.276, eff. August 3, 1977.
See: 9 N.J.R. 308(a), 9 N.J.R. 416(c).
As amended, R.1979 d.148, eff. July 1, 1979.
See: 11 N.J.R. 118(a), 11 N.J.R. 224(a).
As amended, R.1982 d.120, eff. April 19, 1982 (operative September 1, 1982).
See: 13 N.J.R. 914(b), 14 N.J.R. 385(a).
Section substantially amended.

6:29-4.3 Communicable disease

(a) The rules of a district board of education pertaining to the prevention and control of communicable disease, including a readmission policy,

in schools shall be distributed to all principals, medical inspectors, and nurses. The rules shall be explained by the health service staff to the entire school personnel at the beginning of each school year.

(b) Any pupil who appears to be ill or who is suspected of having a communicable disease shall be excluded from school or isolated at school to await instructions from or the arrival of an adult member of his or her family, the medical inspector or the school nurse.

(c) Any pupil retained at home or excluded from school by reason of having or suspected of having communicable disease shall not be readmitted to his or her classroom until he or she presents written evidence of being free of communicable disease. Such evidence may be by a qualified physician or the medical inspector who has examined the pupil.

(d) The rules of the local board of health or the State Department of Health pertaining to communicable diseases among school children shall apply in determining periods of incubation, communicability, quarantine, and reporting.

As amended, R.1984 d.264, eff. July 2, 1984.
See: 16 N.J.R. 300 (a), 16 N.J.R. 1731(a).
(e) deleted.

6:29-4.4 Record and reports

(a) Each medical inspector shall record the results of examinations upon a record form recommended by the Commissioner of Education. Such form shall be kept in a permanent file and shall be the property of the district board of education and shall be preserved. The original health record shall be forwarded with other school records of pupils who transfer to another school district. If a child leaves school for any other reason, the record shall remain the property of the school.

(b) The results of health examinations or of emergency treatment administered or recommended by the medical inspector shall be reported to parents.

As amended, R.1984 d.264, eff. July 2, 1984.
See: 16 N.J.R. 300 (a), 16 N.J.R. 1731(a).
Section substantially amended.

6:29-4.5 Nursing services

All nurses engaged in any capacity in the public schools shall comply with the rules and regulations of the district board or boards of education having jurisdiction, and shall be subject to the administrative authority of such school and school districts.

As amended, R.1984 d.264, eff. July 2, 1984.
See: 16 N.J.R. 300 (a), 16 N.J.R. 1731(a).
"local" changed to "districts."

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SUBCHAPTER 5. SCHOOL SAFETY

6:29-5.1 Rules and regulations

(a) Every board of education in this State shall adopt rules to govern the supervision of pupil safety in its school district and such rules and regulations shall include as a minimum the rules and regulations of the State Board of Education which are expressed in the following sections.

(b) The safety rules of the board of education and the preventive measures and practices applicable to local conditions shall be explained to the personnel by principals at the beginning of each school year and copies of the rules and procedures shall be posted in schools at points conveniently accessible to the personnel.

Case Note

Presence of properly certified school nurse in school building.
See, *Smith v. Bd., of Ed., Caldwell-W. Caldwell,* 1972 S.L.D. 232.

6:29-5.2 Accident prevention

(a) Principals shall introduce and administer precautionary measures and practices to prevent accidents, panic, and fire.

(b) It shall be the duty of every local board of education maintaining courses in health, safety, physical education, practical arts education, and operating a cafeteria or lunchroom, to provide and maintain suitable and safe equipment.

(c) Shop equipment shall not be used for any purpose other than shop instruction. The shop teacher shall be held responsible for the condition of shop tools and equipment, and he shall have full authority for its use for instructional purposes only.

Case Note

Presence of properly certified school nurse in school building.
See, *Smith v. Bd., of Ed., Caldwell-W. Caldwell,* 1972 S.L.D. 232.

6:29-5.3 Safety patrols

(a) Any organization of pupils whether designated as a patrol, council court, club, committee, or school police which has for its purpose the prevention of accidents to pupils in the school building, on the school grounds, on a sidewalk or path adjacent to a street, road, or highway, or in a school bus or other vehicle approved for the transportation of pupils shall be regarded as an essential part of the school program and as a method of safety instruction and shall be employed and administered as such by the school personnel.

(b) The practice of using pupil safety patrols to direct pupil traffic across streets, roads, or highways or to serve in any capacity shall be permitted only when approved by the board of education.

(c) No person, organization, or public agency shall organize, direct or instruct any form of pupil safety organization in a public school except as authorized by the board of education.

(d) A pupil desiring to serve on a school safety patrol or with any similar organization performing patrol duties shall file with the school principal a signed application form and a form of consent signed by one parent or legal guardian. The forms shall be provided by the board of education and they shall be worded in a manner to indicate that the applicant and his parent or guardian are aware of the possible hazards of patrol duty and that in case of injury to himself no liability shall be attached to the board of education or to any employee of the board of education.

(e) Boards of education shall cause all applicants for appointment to a safety patrol and their parents to be informed of all purposes and activities of the patrol and the possible hazard in line of duty.

(f) One or more members of the school staff shall be assigned to the safety patrol in the capacity of advisor or supervisor.

(g) Under no circumstances shall school patrols be vested with authority to direct vehicular traffic, nor shall a patrol member stand in the street while vehicles are passing.

SUBCHAPTER 6. PHYSICAL EDUCATION AND ATHLETICS PERSONNEL AND PROCEDURES

Authority

N.J.S.A. 18A:4-15, 18A:6-38, 18A:35-5 and 18A:35-7.

Source and Effective Date

R.1984 d.192, eff. May 21, 1984
See: 16 N.J.R. 303(a), 16 N.J.R. 1197(a).

Executive Order 66(1978) Expiration Date

Pursuant to the requirements and criteria of Executive Order 66(1978), this subchapter expires on May 1, 1989, as established by readoption R.1984 d.192, effective May 21, 1984. See: 16 N.J.R. 303(a), 16 N.J.R. 1197(a).

6:29-6.1 Physical education personnel

(a) In all schools not having the services of certificated physical education teachers, the responsibility for the program of activities and instruction shall be that of each teacher, or such responsibility may be delegated to one or more teachers designated by the superintendent of schools.

(b) Any person not certified as a teacher and not in the employ of a district board of education shall not be permitted to organize public school pupils during school time or during any recess in the school day for purposes of instruction; or for conducting games, events or contests in physical education.

As amended, R.1984 d.192, eff. May 21, 1984.
See: 16 N.J.R. 303(a), 16 N.J.R. 1197(a).
The word "not" was inserted.

6:29-6.2 Physical education procedures

(a) The foundation program in physical education for the public schools of this State shall be the program as provided in this chapter. District boards of education may, at their discretion, accept the successful completion of basic training in the military or naval service of the United States or United States Merchant Marine in full satisfaction of the physical training requirements of N.J.S.A. 18A:35-7.

(b) A district board of education may give approval for members of an interscholastic athletic team of a school to be excused from physical activity in their physical education class on the days that a regular interscholastic game is scheduled. This approval applies only to those members listed for participation in the game.

(c) District boards of education shall provide by regular appropriations suitable and adequate equipment for carrying out the program for physical education activities.

(d) A district board of education may adopt a policy to permit pupils to receive graduation credit in physical education while participating in interscholastic team activity, alternative programs of athletics, or alternative programs of physical education activities that meet the requirements of N.J.A.C. 6:8-4.2 and are consistent with local district's physical education program goals and instructional objectives. Health and safety requirements must be satisfied, pursuant to the provisions of N.J.S.A. 18A:35-5. Any policy adopted under this authority shall include, but need not be limited to, the following provisions:

1. The principal, in consultation with an appropriately certificated staff member(s), shall, upon application by the pupil and parents, or guardian, determine the appropriateness of the interscholastic activity, alternative athletic program, or physical education activity.

2. To be eligible to receive graduation credit in physical education through interscholastic team activity, alternative programs of athletics, or alternative programs of physical education activities the pupil must:

i. Be enrolled in a four-year or senior high school;

ii. Demonstrate that the interscholastic activity or alternative program will provide activity and development equivalent to that provided by the physical education program.

3. Credit and grading for the alternative program shall be given through the administrative procedures of the local physical education program.

4. The permanent school records shall indicate the credits granted for physical education through the alternative program.

5. If the alternate program leaves unscheduled time during the school day, the pupil shall use the time for scholastic purposes.

As amended, R.1984 d.192, eff. May 21, 1984.
See: 16 N.J.R. 303(a), 16 N.J.R. 1197(a).
Section substantially amended.

6:29-6.3 Athletics personnel

(a) No person not certified as a teacher and not in the employ of a board of education shall be permitted to organize public school pupils during school time or during any recess in the school day for purposes of instruction; or coaching or for conducting games, events or contests in physical education or athletics.

(b) School districts shall be permitted to employ any holder of a New Jersey teaching certificate to work in the interscholastic athletic program provided that the position has been advertised.

(c) In the event there is no qualified and certified applicant, the holder of a county substitute certificate is authorized to serve as an athletic coach

in the district in which he or she is employed for a designated sports season, provided that:

1. The district superintendent demonstrates to the county superintendent that:

i. The vacant coaching position had been advertised; and

ii. There was no qualified applicant based on the written standards of the district board of education.

2. The district superintendent will provide a letter to the county superintendent attesting to the prospective employee's knowledge and experience in the sport in which he or she will coach;

3. Approval of the county superintendent shall be obtained prior to such employment by the district board of education. The 20-day limitation noted in N.J.A.C. 6:11-4.7(c) shall not apply to such coaching situations.

As amended, R.1972 d.88, eff. May 8, 1972.
See: 4 N.J.R. 65(b), 4 N.J.R. 118(a).
As amended, R.1973 d.223, eff. August 10, 1973.
See: 5 N.J.R. 298(b).
As amended, R.1977 d.69, eff. March 3, 1977.
See: 9 N.J.R. 67(a), 9 N.J.R. 167(b).
As amended, R.1982 d.486, eff. January 17, 1983.
See: 14 N.J.R. 1010(a), 15 N.J.R. 84(c).
Added (f).
As amended, R.1983 d.493, effective November 7, 1983.
See: 15 N.J.R. 1152(b), 15 N.J.R. 1860(c).
Deleted old (b)-(f) and added new (b)-(c).

Case Notes

Qualifications for school coaches.

Barber and Kelner v. Bd. of Ed., Kearny, Hudson Cty., 1975 *S.L.D.* 58, 1976 *S.L.D.* 1105.
Brick Tp. Ed. Ass'n v. Bd. of Ed., Brick, Ocean Cty., 1975 *S.L.D.* 265, 1975 *S.L.D.* 268.
Point Pleasant Teacher's Ass'n v. Bd. of Ed., Point Pleasant Beach, Ocean Cty., 1974 *S.L.D.* 241.

6:29-6.4 Athletics procedures

(a) The program of activities or sports to be employed by any public school in competitive contests, games or events or in exhibitions with individual pupils or teams of one or more schools of the same district, or of other districts, shall be recommended annually by the chief school administrator to the district board of education for approval.

(b) In cases in which the athletic facilities are not owned by the municipality or the district board of education, the district board of education shall require that adequate safeguards to players and spectators be provided by the owner. The field, room, court, track, stands and surrounding premises shall be kept in good condition and free from hazards.

(c) Upon the recommendation of the chief school administrator, the district board of education shall adopt, and thereafter, annually review a policy of emergency medical procedures for all practice sessions, and competitive contests, games, events or exhibitions with individual pupils or teams of one or more schools of the same district or of other districts. Said policy should be disseminated to appropriate personnel.

(d) Good physical condition, freedom from injury and full recovery from illness shall be prerequisites to participation in athletics, whether in practice or in competition. Each candidate for a place on a school athletic squad or team shall be given a medical examination by the medical inspector or designated team doctor no more than 60 days prior to the first practice session or in lieu thereof, the medical inspector may accept the report of such an examination by a physician licensed to practice medicine. Any examination which shall be used to determine the fitness of a pupil to participate in athletics shall not be given before the first day of the school year, as defined in N.J.S.A. 18A:36-1, for which such fitness is being determined. Each candidate must undergo one medical examination in each school year. The parent or legal guardian shall receive written notification signed by the medical inspector or team doctor testifying to the pupil's physical fitness to participate in athletics. The reasons for the medical inspector's or team doctor's approval or disapproval of the pupil's participation shall be included in such notification. The health findings of the medical examination for participation in athletics shall be made a part of the general health examination record.

(e) A medical examination to determine the fitness of a pupil to participate in athletics shall include, as minimum, no less than the following:

1. A medical history questionnaire, completed by the parent or legal guardian of the pupil, to determine if the pupil:

i. Has been medically advised not to participate in any sport, and the reason for such advice;

ii. Is under physician's care and the reasons for such care;

iii. Has experienced loss of consciousness after an injury;

iv. Has experienced a fracture or dislocation;

v. Has undergone any surgery;

vi. Takes any medication on a regular basis, the names of such medication and the reasons for such medication;

vii. Has allergies including hives, asthma and reaction to bee stings;

viii. Has experienced frequent chest pains or palpitations;

ix. Has a recent history of fatigue and undue tiredness;

x. Has a history of fainting with exercise; and

xi. Has a history of a family member having sudden death.

2. A physical examination which shall include, as a minimum, no less than the following:

i. Measurement of weight, height and blood pressure;

ii. Examination of the skin to determine the presence of infection, scars of previous surgery or trauma, jaundice and purpura;

iii. Examination of the eyes to determine visual acuity, use of eyeglasses, or contact lenses, and examination of the sclera for the presence of jaundice;

iv. Examination of the ears to determine the presence of acute or chronic infection, perforation of the eardrum and gross hearing loss;

v. Examination of the nose to assess the presence of deformity which may affect endurance;

vi. Assessment of the neck to determine range of motion and the presence of pain associated with such motion;

vii. Examination of chest contour;

viii. Auscultation and percussion of the lungs;

ix. Assessment of the heart with attention to the presence of murmurs, noting rhythm and rate before and after exercise;

x. Assessment of the abdomen with attention to the possible presence of heptamegaly, splenomegaly or abnormal masses;

xi. Assessment of the back to determine range of motion and abnormal curvature of the spine;

xii. Examination of extremities to determine abnormal mobility or immobility, deformity, instability, muscle weakness or atrophy, surgical scars and varicosities;

xiii. Examination of the testes to determine the presence and descent of both testes, abnormal masses or configurations, or hernia;

xiv. Assessment of physiological maturation; and

xv. Neurological examination to assess balance and coordination and the presence of abnormal reflexes; and

(f) The district board of education shall adopt policy regarding the content and procedures for the administration of the medical examination required in (d) above. Nothing in this section shall be interpreted as precluding the district board of education from adopting content and procedures in excess of the minimum requirements set forth herein. Any examination conducted by a physician other than the medical inspector or designated team doctor must be reported to the medical inspector or designated team doctor on a form furnished by the district board of education and, as a minimum, include that content adopted by the board. If, at the request of the parent or legal guardian, the medical examination is conducted by a physician other than the medical inspector or designated team doctor, such examination shall not be at the expense of the district board of education.

(g) A pupil representing his or her school in interscholastic athletic competition shall sign a form furnished by the district board of education, the wording of which shall embody a request to be enrolled as a candidate for a place on a school team in a specified sport. The parent or legal guardian must execute an acknowledgement that physical hazards may be encountered.

(h) Every candidate for a place on the school athletic squad or team shall submit a form furnished by the district board of education conveying the consent of his or her parent or legal guardian to participate.

As amended, R.1972 d.87, eff. May 8, 1972.
See: 4 N.J.R. 65(a), 4 N.J.R. 117(c).
As amended, R.1984 d.192, eff. May 21, 1984.
See: 16 N.J.R. 303(a), 16 N.J.R. 1197(a).
Substantially amended.
Amended by R.1985 d.281 effective June 3, 1985.
See: 17 N.J.R. 659(a), 17 N.J.R. 1410(a).
Substantially amended.

Case Note

Participation on interscholastic soccer team contingent on discretion of medical inspector. *"P.N." by his parents v. Bd. of Ed., Elizabeth, Union Cty.*, 1975 *S.L.D.* 783.

SUBCHAPTER 7. FAMILY LIFE EDUCATION PROGRAM

Authority

N.J.S.A. 18A:4-10, 18A:4-15, 18A:7A-1, 18A:33-1, 18A:35-4.6, 18A:35-5, 18A:36-5, 18A:35-7.

Source and Effective Date

R.1985 d.185, effective March 25, 1985.
See: 16 N.J.R. 3377(a), 17 N.J.R. 906(a).

Executive Order 66(1978) Expiration Date

Pursuant to the requirements and criteria of Executive Order 66(1978), this subchapter expires on March 25, 1990.

Historical Note

All provisions of this subchapter were filed and became effective April 17, 1980 as R.1980 d.164. See: 12 N.J.R. 105(b), 12 N.J.R. 251(b). Amendments were filed and became effective August 7, 1980 as R.1980 d.353. See: 12 N.J.R. 388(c), 12 N.J.R. 505(c). A readoption became effective March 25, 1985 and amendments became effective April 15, 1985 as R.1985 d.185. See: 16 N.J.R. 3377(a), 17 N.J.R. 906(a). See chapter and section levels for further amendments.

6:29-7.1 Family life education

(a) As used in this subchapter, "family life education program" means instruction to develop an understanding of the physical, mental, emotional, social, economic, and psychological aspects of interpersonal relationships; the physiological, psychological and cultural foundations of human development, sexuality, and reproduction, at various stages of growth; the opportunity for pupils to acquire knowledge which will support the development of responsible personal behavior, strengthen their own family life now, and aid in establishing strong family life for themselves in the future thereby contributing to the enrichment of the community.

(b) The family life education curriculum shall be developed through appropriate consultation and participation of teachers, school administrators, parents and guardians, pupils in grades 9 through 12, community members, physicians, members of the clergy and representative members of the community. The district board of education shall demonstrate prior to the initiation of any district board of education program that the above consultation and participation have taken place. The process of consultation shall be continued as the program is revised in future years.

1. The parents and guardians of pupils enrolled in the district shall receive annually an outline of the curriculum and a list of instructional materials for the grade of their child including notification about how to receive a copy of the curriculum. The district shall make available for review in each school the complete curriculum and all instructional materials prior to use in the classroom. Upon the request of parents and guard-

ians, the material shall be made available for their review.

(c) The district's family life education program shall be implemented comprehensively through the coordinate sequential elementary/secondary curriculum with instructional units appropriate to the age, growth and development, and maturity of the pupils.

(d) Districts that develop their program with an interdisciplinary approach may use teachers from other disciplines to assist those staff members authorized to give instruction in family life education.

(e) Teaching staff members holding one of the following certificates are authorized to teach in the district's family life education program:

1. Biology;
2. Comprehensive science;
3. Elementary;
4. Health education;
5. Health and physical education;
6. Home economics;
7. Nursery;
8. School nurse;
9. Teacher of psychology;
10. Special Education.

(f) Districts may use resource people to assist with their program; that is, physicians, members of the clergy, attorneys, parents and guardians, school social workers, school psychologists, law enforcement personnel, and others as necessary.

(g) The district board of education shall provide for in-service education to those teachers responsible for family life education programs.

(h) The State Department of Education shall provide technical assistance to district boards of education in the development of family life education programs.

(i) The district board of education shall establish procedures whereby any pupil, whose parent or guardian presents to the school principal a signed statement that any part of the instruction in family life education is in conflict with his or her conscience, or sincerely held moral or religious beliefs, shall be excused from that portion of the course where such instruction is being given and no penalties as to credit or graduation shall result therefrom (N.J.S.A. 18A:35-4.6 et seq.).

(j) This subchapter is subject to all of the provisions of N.J.A.C. 6:8-4.2.

Amended by R.1985 d.185, effective March 25, 1985.
See: 16 N.J.R. 3377(a), 17 N.J.R. 906(a).
Substantially amended.

Case Note

Validity of regulation affirmed.
Smith v. Ricci, 89 *N.J.* 514 (1982).

SUBCHAPTER 8. AUDIOMETRIC SCREENING

Authority

N.J.S.A. 18A:4-15 and 18A:40-4

Source and Effective Date

R.1982 d.195, eff. June 21, 1982 (operative September 1, 1982).
See: 14 N.J.R. 108(a), 14 N.J.R. 654(c).

Executive Order 66 (1978) Expiration Date

Pursuant to the requirements and criteria of Executive Order 66 (1978), this subchapter expires on April 1, 1987.

6:29-8.1 Definitions

The following words and terms, when used in this subchapter, shall have the following meanings unless the context clearly indicates otherwise.

"Audiometer" means an electroacoustical generator which provides pure tones at selected frequencies of output through calibrated earphones mounted in MX41/AR earmuffs. Audiometers shall be calibrated annually in accordance with ANSI S3.6–1969, American National Standard Specifications for Audiometers, which with all subsequent amendments and supplements is hereby adopted as a rule.

1. This document is available for review at the Division of School Programs, Department of Education, 225 West State Street, CN 500, Trenton, New Jersey 08625, or at the Office of Administrative Law, CN 301, Trenton, New Jersey 08625.

2. This document may be purchased from the American National Standards Institute, Inc., 1430 Broadway, New York, New York 10018.

"Audiometric screening" means a procedure used to determine a pupil's response to an auditory signal at a given frequency and decibel level.

"Health care personnel" means a certified school nurse or an employee of the district board of education trained in audiometric screening and who is working under the immediate direction of the medical inspector, including but not limited to speech correctionists and audiologists.

"Pupils at risk for hearing impairment" means pupils with communication disorders, pupils with cleft palate, pupils with allergies, pupils with frequent upper respiratory or middle ear infections, pupils taking ototoxic medication, pupils who are exposed to sudden or continuous loud noises.

"Screening room" means any environment in which an adult with normal hearing can hear a 20dB HL signal at the frequencies of 500Hz, 1000Hz, 2000Hz, 3000Hz and 4000Hz.

6:29-8.2 Screening procedures

(a) Each district board of education shall develop and adopt policies and procedures to provide audiometric screening.

(b) Auditory screening shall be conducted for pupils who are:

1. Enrolled in pre-school programs;
2. Enrolled in grades kindergarten through 4;
3. Enrolled in grades 6, 8, and 9 or 10;
4. Entering the district with no recent record of hearing screening;
5. At risk for hearing impairments;
6. Referred to the Child Study Team for evaluation;
7. Referred for screening by a teacher, a parent or at the pupil's own request.

(c) The medical inspector, certified school nurse, or the health care personnel shall conduct the hearing screening. All screening shall be conducted in cooperation with the school nurse.

(d) Each pupil shall be screened individually with an audiometer which is calibrated annually in accordance with ANSI S3.6–1969, American National Standard Specifications for Audiometers, at 20dB HL in a screening room at the following frequencies: 500 Hz, 1000Hz, 2000Hz, 3000Hz, and 4000Hz.

(e) A pupil who fails to respond to any one frequency in either ear shall be screened again in four to six weeks.

(f) If a pupil fails to respond to the same frequency or frequencies in the same ear on the second valid screening, the pupil shall be considered to have failed the screening and should be referred for further evaluation.

(g) A pupil who fails to respond at a different frequency or different frequencies on the second screening shall be screened a third time within two weeks.

(h) A pupil who fails to respond at any one frequency on the third screening shall be considered to have failed the screening and should be referred for further evaluation.

(i) The parent or guardian of pupils failing auditory screening shall be notified in writing by the school nurse of the necessity for additional evaluation by a physician or family health care provider.

APPENDIX D

NURSING/HEALTH PROFESSIONAL ORGANIZATIONS, RESOURCES, AND PUBLICATIONS

Professional Organizations

American Nurses' Association
2401 Perishing Road
Kansas City, Missouri 64108
(816) 474-5720

American School Health Association
P.O. Box 708
Kent, Ohio 44240

National Association of School Nurses
(Affiliate of NEA)
New York Statler - Suite 104
7th Avenue & 33rd Street
New York, New York 10001

National Education Association
1201 16th Street, N.W.
Washington, New Jersey 20036

New Jersey Board of Nursing
1100 Raymond Boulevard
Newark, New Jersey 07102
(201) 648-2490

New Jersey Education Association
180 West State Street
Trenton, New Jersey 08608

New Jersey League for Nursing
1020 Galloping Hill Road
Union, New Jersey 07083
(201) 687-0891

New Jersey State Nurses' Association
320 West State Street
Trenton, New Jersey 08625

New Jersey State School Nurses' Association
180 West State Street
Trenton, New Jersey 08608

Resources

American Academy of Pediatrics
New Jersey Chapter
210 Carnegie Center #207
Princeton, New Jersey 08540
(609)987-0077

American Cancer Society
777 3rd Avenue
New York, New York 10017
N.J. Chapter: 1672 Highway 27, Edison, NJ 08817

American Diabetes Association
1 West 48th Street
New York, New York 10020
N.J. Affiliate: 345 Union St., Hackensack, NJ 07601

American Foundation for the Blind
15 West 16th Street
New York, New York 10011

American Heart Association
7310 Greenville Avenue
Dallas, Texas 75231
N.J. Affiliate: 1525 Morris Ave., Union, NJ 07083)

American National Red Cross
17th and D Streets, N.W.
Washington, D.C. 20006
N.J. Affiliate: 106 Washington St., East Orange, NJ 07017

American Optometric Association
(Re: Ishihara Color Plates and/or Massachusetts Vision Test)
1730 M Street, N.W.
Washington, D.C. 20036
(201) 833-9899

Council for Exceptional Children
1920 Association Drive
Reston, Virginia 22091

Epilepsy Foundation of America
1828 "L" Street, N.W.
Washington, D.C. 20036
N.J. Affiliate: 303 George Street, New Brunswick, NJ 08901

The Good-Lite Company
(Re: Snellen Charts)
7426 West Madison Avenue
Forrest Park, Illinois

High Blood Pressure Information Center
(Re: posters and materials for nurses, physicians,
program planners and consumers)
120/80 National Institute of Health
Bethesda, Maryland 20014

National Association for Deaf/Blind
2703 Forest Oak Circle
Norman, Oklahoma 73071

National Society for the Prevention of Blindness, Inc.
16 East 40th Street
New York, New York

National Society to Prevent Blindness (N.J.)
303 George Street
New Brunswick, New Jersey 08901

New Jersey State Commission for the Blind and Visually Impaired
1100 Raymond Boulevard
Newark, New Jersey 07102

New Jersey State Department of Health
John Fitch Plaza CN 360
Trenton, New Jersey 08625

New Jersey State Department of Human Services
One Capital Place
222 South Warren Street
Trenton, New Jersey 08625

Thomas Optical Company
(Re: Thomas Optical School Vision Tester)
Petersburg, Virginia

Unversity of Chicago Press
(Re: Child Development)
5801 Ellis Avenue
Chicago, Illinois 60637

Welch Olzen Company
(Re: Massachusetts Vision Test)
Skaneateles Fall, New York

Publications

Alexander, Mary M., R.N. M.S. and Brown, Marie Scott, R.N., Ph.D. Pediatric History Taking and Physical Diagnosis for Nurses. New York, McGraw Hill Book Co., 1979, pgs. 303, 304.

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Levine, Melvin D., M.D., Brooks, Robert Ph.D., and Shonkoff, Jack P.M.D. Pediatric Approach to Learning Disorders. John Wiley and Sons, New York, 1980.

Malasnas, Lois R.N., Ph.D., Barkaukas, Violet R.N., M.P.H., Mass, Muriel R.N., M.A. and Kathryn Stoltenberg-Allen, R.N., M.S.N., Health Assessment. 2nd. Ed., The C.V. Mosby Company, St. Louis, 1981, pgs. 449-451.

National Association of School Nurses, Inc., Guidelines for a Model School Nurse Services Program. Englewood, Colorado, 1981.

National Association of School Nurses, Inc., The School Nurse. NEA, Englewood, Colorado.

Powell, Marcene L., R.N., M.N., Assessment and Management of Developmental Changes in Children. 2nd. Ed., The C.V. Mosby Co., St. Louis, 1981.

Rainbow Youth Spine Center, "Brace Yourself -- Scoliosis and the Milwaukee Brace," 2065 Adelbert Road, Cleveland, Ohio 44106.

Rainbow Youth Spine Center, "What if You Need an Operation for Scoliosis?," 2065 Adelbert Road, Cleveland, Ohio 44106.

Scoliosis Research Society, "Scoliosis - A Handbook for Parents," Suite 800, Chicago, Illinois 60611.

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